

**BRECKSVILLE-BROADVIEW HEIGHTS CITY SCHOOLS  
EMERGENCY MEDICAL AUTHORIZATION**

Student's Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Birthdate \_\_\_\_\_ Date of last Tetanus shot \_\_\_\_\_

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_

Other person(s) to be contacted if above parent/guardian cannot be reached:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**History of Child**

Student's Allergies: List) \_\_\_\_\_

Describe the type of reaction: \_\_\_\_\_

List medications to treat allergy : \_\_\_\_\_

**(All medications must be provided by parent and must be accompanied by medication authorization form-forms can be found on the district page of the school website: [www.bbhcsc.org](http://www.bbhcsc.org) under health services)**

Daily Medications \_\_\_\_\_ Times Given \_\_\_\_\_

Reason Given \_\_\_\_\_

Seizures (Describe) \_\_\_\_\_

Hearing Problems \_\_\_\_\_ Vision Difficulty \_\_\_\_\_ Lenses or Contacts \_\_\_\_\_

Diabetes \_\_\_\_\_ Management \_\_\_\_\_

Asthma \_\_\_\_\_ Management \_\_\_\_\_

Any Other Health Concerns \_\_\_\_\_

Any social/emotional concerns \_\_\_\_\_

**PART I OR PART II MUST BE COMPLETED ON REVERSE SIDE**

**PART I: TO GRANT CONSENT**

**I hereby give consent** for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone ( \_\_\_\_ ) \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Phone No ( \_\_\_\_ ) \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

If needed, I prefer to have my child transported by the EMS to:

- Marymount South – Broadview Heights  Marymount Hospital – Garfield Heights
- Parma Hospital – Parma

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

**PART II REFUSAL OF CONSENT**

**I do NOT give my consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_