BRECKSVILLE-BROADVIEW HEIGHTS CITY SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME _____ **DATE OF BIRTH** ___/___/___ **GR** [ ] **HOMEROOM** [ ]
Print

ADDRESS _____ **SCHOOL** _____
Street (Apt#) City State/Zip

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.

LIST NAMES TO CONTACT IN CASE CHILD BECOME ILL/INJURIED

Residential Parent/Guardian	*Name (Print)*	*Daytime Phone*	*Other Phone*
Mother/Guardian			
Father/Guardian			
Relative/Childcare Provider			
Other person/Relationship			
Other person/Relationship			

NOTE: PART I OR **PART II *MUST* BE COMPLETED AND SIGNED**

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	☒ Closest	Phone: ( ) -
Other	_____	Phone: ( ) -

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.

Facts concerning the child's medical history including allergies (life threatening) , medications being taken, and any physical impairments to which a physician should be alerted:

Allergies _____
Medication _____
Physical Impairments _____

☐ Asthma _____ ☐ Diabetes _____ ☐ Seizures _____

X PARENT/GUARDIAN _____ **DATE:** ___/___/___
Signature

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:

_____
_____

X PARENT/GUARDIAN _____ **DATE:** ___/___/___
Signature