

Beavercreek High School
2660 Dayton-Xenia Road
Beavercreek OH 45434

EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT NAME: _____ SPORT: _____

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

Residential Parent/Guardian:

Mother's Name: _____ Home phone: _____
Work phone: _____
Cell: _____

Father's Name: _____ Home phone: _____
Work phone: _____
Cell: _____

Other: _____ Home phone: _____
Relationship: _____ Work phone: _____
Cell: _____

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: _____

Local Hospital: _____ 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, medications being taken, and any physical impairment to which a physician should be alerted:

Date: _____
Signature of Parent/Guardian: _____

PART II: REFUSAL TO 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 actions: _____

Date: _____
Signature of Parent/Guardian: _____