HERITAGE CHRISTIAN PRESCHOOL • 2107 6TH STREET SW • CANTON, OH 44706

PHONE: 330.452.8271 • FAX: 330.452.0672

EMERGENCY MEDICAL AUTHORIZATION

Student Name___________________________Family Name_________________D.O.B.___/___/___ Grade_______
Street Address_________________________City______________Zip Code___________Phone__________________

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 (names of people you wish to be contacted):
Mother's Name_____________________Day Phone_________________ Cell Phone Number___________________
Mother's Employer___________________ Address___________________________ Bus. Phone________________
Email Address____
Father's Name_________________________Day Phone_______________Cell Phone_________________________
Father's Employer ______________________ Address________________________ Bus. Phone_________________
Email Address____
Other Name_______________________Day Phone__________________ Cell Phone___________________________
Employer____________________ Address_______________________________ Bus. Phone____________________
Name of Relative or Childcare Provider______________________________Phone______________________
Relationship______________________Address____

PART I OR II MUST BE COMPLETED

PART I – TO GRANT CONSENT:

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

Doctor____Phone___________________________________

Dentist____Phone___________________________________

Medical Specialist__________________________________Phone___________________________________

Local Hospital____________________________________ Emergency Room 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 doctor, 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 dentist, 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:

Allergies____

Medications being taken, history of hospitalizations, diseases child has had:

____

Other medical information, food supplements, modified diets, fluoride supplements

____

SIGNATURE OF PARENT/GUARDIAN__________________________________DATE_____________________

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EMERGENCY MEDICAL AUTHORIZATION – SIDE 2

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 emergency treatment, I wish the school authorities to take the following action:

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SIGNATURE OF PARENT/GUARDIAN____**DATE**____________________

IMPORTANT – ALL PARENTS
PLEASE FILL OUT INFORMATION BELOW

If we, the parent or guardian, cannot be reached or cannot pick up my/our child/children in case of an emergency or national crisis, I authorize these people, in priority order, to pick up my child/children:

	NAME	RELATIONSHIP	PHONE
1.	________________________________	___________________	_________________________
2.	________________________________	___________________	_________________________
3.	________________________________	___________________	_________________________
4.	________________________________	___________________	_________________________
5.	________________________________	___________________	_________________________
6.	________________________________	___________________	_________________________

We realize if there are any changes/additions/deletions in any of this information or information on the **EMERGENCY MEDICAL FORM**, we need to send it in writing ***as soon as possible.***

SIGNATURE OF PARENT/GUARDIAN____________________________________ **DATE**______________________