

HERITAGE CHRISTIAN SCHOOL • 2107 6<sup>TH</sup> STREET SW • CANTON, OH 44706

PHONE: 330.452.8271 • FAX: 330.452.0672

**EMERGENCY MEDICAL AUTHORIZATION**

Student Name \_\_\_\_\_ Family Name \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_ 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:

<b>NAME</b>	<b>RELATIONSHIP</b>	<b>PHONE</b>
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** \_\_\_\_\_