ST. CLAIRSVILLE-RICHLAND CITY SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION

(REQUIRED PER HB 639)

STUDENT NAME _____ **GRADE**_____

ADDRESS _____ **HOME PHONE** _____

WITH WHOM DOES THE CHILD RESIDE? _____

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority. By listing the people below, you are giving permission for them to pick up your child from school. In an emergency situation, parents/relatives would be contacted in the order listed below.

NAME	HOME PHONE	CELL PHONE	WORK PHONE	RELATIONSHIP TO STUDENT
1.) _____	_____	_____	_____	_____
2.) _____	_____	_____	_____	_____
3.) _____	_____	_____	_____	_____
4.) _____	_____	_____	_____	_____

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

I also give permission to the school nurse or designee to administer the following **non-prescription** medications to my child: Tums, cough drops as needed.

Facts concerning the child's **medical history, including allergies, medications** being taken, and any physical impairment to which a physician should be alerted:

_____

_____

SIGNATURE OF PARENT/GUARDIAN _____**DATE** _____

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 action:

_____

SIGNATURE OF PARENT/GUARDIAN _____**DATE** _____