EMA051507

EMERGENCY MEDICAL AUTHORIZATION

Montpelier Exempted Village Schools
1015 E. Brown Rd.
PO. Box 193
Montpelier, OH 43543
419-485-6700

Student Name: _____

Address: _____

City, St. Zip: _____

Date of Birth: _____ Grade: _____

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.

☐ Father ☐ Stepfather ☐ Guardian ☐ Other

Name _____

Address _____

City _____ Zip _____

Phone Number _____

Cell Phone _____

Employer _____

Employer's Phone _____

☐ Mother ☐ Stepmother ☐ Guardian ☐ Other

Name _____

Address _____

City _____ Zip _____

Phone Number _____

Cell Phone _____

Employer _____

Employer's Phone _____

First Contact: ☐ Father ☐ Mother ☐ Other Emergency Contact

Emergency Contact
(Other than a parent or guardian listed above)

Name _____ Phone Number _____

Address _____ Relationship _____

City _____ Zip _____

Part I or Part II must be completed.
Part III optional.

Part I
To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called in the case of an emergency:

_____ _____
Doctor's Name Phone Number

_____ _____
Dentist's Name Phone Number

_____ _____
Preferred Local Hospital Phone Number

In the event that reasonable attempts to make contact with above named individuals have been unsuccessful, I hereby give my consent for (1) 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 dentists, concurring in the necessity for surgery, are obtained prior to the performance of such surgery.

_____ _____ _____
Name of Parent/Guardian Authorizing consent Signature of Parent/Guardian Authorizing consent Date

Part II and Part III on next Page

Part II
Refusal To Grant Consent

Do not complete if you completed Part I

I do **NOT** give my consent for emergency medical treatment of my child.

In the event that reasonable attempts to make contact with above named individuals have been unsuccessful, I wish the school authorities to take the following action:

Name of Parent/Guardian Refusing Authorization	Signature of Parent/Guardian Refusing Authorization	Date

Part III
Medical History

Optional

Facts concerning your child's medical history including allergies, medications being taken, and any physical impairments. This information will be shared with appropriate school district personnel only.
