

Lowellville School District
Emergency Medical Authorization Form

Student Name: _____ Birth Date: _____ Grade: _____
Address: _____ City/Zip Code: _____
Phone #: _____ Bus Number: _____ Student lives with: _____
Parent/Guardian #1 Email Address: _____
Parent/Guardian #2 Email Address: _____

PARENTS/GUARDIAN(S) AND EMERGENCY CONTACTS

Call Order	Relationship	Name	Phone Number	Can pick up
				Yes No
				Yes No
				Yes No
				Yes No
				Yes No

Please indicate if your child has any of the following:

- Allergies (please list): _____

- Medications (please list): _____

- Other medical concerns to which medical personnel should be alerted? _____

TO GRANT CONSENT:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physicians below or, if they are not available, by another licensed physician or dentist. I give my consent for my child to be transferred to the hospital below, or any hospital reasonably accessible. This authorization does not cover major surgery unless medical opinions of two licensed physicians or dentists concerning the necessity of such surgery are obtained prior to the performance of such surgery.

Physician: _____ Phone: _____ Dentist: _____ Phone: _____
Hospital: _____ Signature of Parent/Guardian _____ Date: _____

REFUSAL OF 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 to take no action or to _____

Signature of Parent/Guardian _____ Date: _____