LICKING VALLEY LOCAL SCHOOL DISTRICT
STUDENT EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, even if the parents or guardian cannot be reached.

PART 1:

STUDENT NAME	
HOME ADDRESS	
CITY, STATE, ZIP	
HOME PHONE	
BIRTH DATE	
GRADE	
SOCIAL SECURITY	
DATE OF LAST TETANUS	

Student resides with (circle all that apply) Mother Father Step-parent Guardian

Other_____ **Relationship to Student**_____

List only the names of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

ORDER OF CONTACT		NAME	HOME PHONE	CELL PHONE	WORK PHONE
	MOTHER				
	FATHER				
	STEPPARENT				
	GUARDIAN				
	OTHER				

OTHER STUDENTS IN YOUR FAMILY		
NAME	SCHOOL	GRADE

In this box, please indicate any vital information you think we need to know about this student.

Vital Information:

PART 2:

COMPLETE ONLY ONE OF THE FOLLOWING:
I. CONSENT FOR TREATMENT OR II. REFUSAL TO CONSENT

I. CONSENT FOR TREATMENT:

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

Name	Phone Number
Preferred Physician:	
Preferred Dentist:	
Medical Specialist:	
Preferred Hospital:	

AND

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student 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 such surgery are obtained prior to the performance of such surgery.

MEDICAL HISTORY: Facts concerning the student's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

_____

_____

_____

_____

Parent/Guardian Signature:

_____

Date: _____

II. REFUSAL TO CONSENT:

I do **NOT** give my consent for emergency medical treatment of the named student. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____

_____

_____

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_____

_____

Parent/Guardian Signature:

_____

Address:

_____

_____

_____

Date: _____