TIPP CITY EXEMPTED VILLAGE SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

Name _____ Age _____ Phone _____

Address _____

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone no.) or _____ (Other parent) at _____ (phone no.) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr._____ (Preferred physician) or Dr. _____ (Preferred dentist), 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 _____ (preferred hospital) or any hospital reasonably accessible.

Insurance Co. _____ Policy No. _____

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 BEFORE the surgery IS PERFORMED.

IMPORTANT

Please list any health problems that might be significant to a physician evaluating your child in case of an emergency _____

Please list any allergies to medications, etc. _____
Does student suffer from _____ asthma, _____ diabetes, or ___ epilepsy? (Check any that apply.)
Has the student been prescribed an inhaler or EpiPen? _____
Is student presently taking medication? _____ If so, what type? _____
Does student wear contact lenses? _____ Please list date of last tetanus shot _____

DATE:_____ Signature of Parent _____
Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to: _____

DATE: _____ Signature of Parent _____
Address _____