

SPORT(S): _____

**Emergency Medical Authorization
Strongsville City School District**

Grade _____	
Student Name	Home Telephone
(441 _____)	
Student Address	School Attending
Zip _____	

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 PART II MUST BE COMPLETED

PART I (TO GRANT REQUEST)

In the event reasonable attempts to contact me at _____ or _____
 (Daytime Phone Number) (Other Parent)

at _____, or _____ at _____, or _____
 (Daytime Phone Number) (Relative or Childcare Provider) (Daytime Phone Number)

_____ at _____ have been unsuccessful, I hereby give
 (Other Name) (Daytime Phone Number)

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

This authorization does not cover major surgery unless the medical opinions of two other physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

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

Parent/Guardian Signature: _____ **Date:** _____

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:

Parent/Guardian Signature: _____ **Date:** _____