Cincinnati Public Schools

# EMERGENCY MEDICAL AUTHORIZATION

Please fill out the form below and return to your school for their records

| Student's Name | ID Number | Homeroom | Date of Birth |
|---|---|---|---|

School: Hughes Center School Year:

Student's Name _____

Address _____Apt # _____ Telephone _____

City _____State _____ Zip Code _____

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.

**Residential Parent or Guardian**

Mother's Name _____Daytime Phone ( ) _____
First Name Last Name

Father's Name _____Daytime Phone ( ) _____
First Name Last Name

Other's Name _____Daytime Phone ( ) _____
First Name Last Name

Name of Relative or Childcare Provider _____

Relationship _____Daytime Phone ( ) _____

Address _____Zip Code _____

**PART I OR ll MUST BE COMPLETED**

**Part I: TO GRANT CONSENT –** I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____Phone ( ) _____

Dentist _____Phone ( ) _____

Medical Specialist _____Phone ( ) _____

Local Hospital _____Emergency Room # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctors, 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 such surgery, are obtained prior to the performance of such surgery.

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

Date _____Signature of Parent/Guardian _____

**Part II: REFUSAL TO GRANT 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 the following action:

_____
_____
_____

Date: _____ Signature of Parent/Guardian _____