EMERGENCY MEDICAL AUTHORIZATION

Student Name _____ **Date of Birth** _____ **Grade** _____

Custodial Parent/Guardian Name(s) _____

Address _____ **Home Phone** _____

_____ **Cell Phone(s)** _____

Please list facts concerning the child's medical history including allergies (i.e. bee stings, medications, etc.), medications currently being taken, and any physical impairments to which a physician should be alerted:

_____

In case of emergency, illness or accident to the child named above, the school is authorized to proceed as indicated below. (Please number each item 1, 2, 3, etc., in order of desired action):

_____ **Contact Mother at phone** _____

_____ **Contact Father at phone** _____

_____ **Take child to** _____ **Hospital**

_____ **Contact Family Physician** _____ **Phone** _____

_____ **Contact Dentist** _____ **Phone** _____

_____ **Take child to any licensed physician**

_____ **Other** _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

** COMPLETE and "x" EITHER Part I - To Grant Consent OR Part II - Refusal to Consent **

_____ **PART I - Grant Consent: In the event reasonable attempts to contact me at phone #** _____ **or to contact** _____ **at phone #** _____ **have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the doctor or dentist listed above or, in the event the designated preferred practitioner is not available, by another licensed practitioner; and (2) the transfer of the child to the following Hospital** _____ **or 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 before surgery is performed.**

Signature of Parent/Guardian _____ **Date** _____

****Do Not Complete the following Part II if you completed Part I above****

_____ **PART II - Refusal to Grant Consent: <u>I DO NOT</u> give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to either take no action or to** _____

Signature of Parent/Guardian _____ **Date** _____

HEALTH INSURANCE INFORMATION

I hereby release Chippewa Local Schools and its agents from any responsibility in case of injury, illness, or propery damage sustained by my child in connection with participation in the school's athletic program.

Name of Responsible Party _____ **GROUP POLICY #** _____

_____ **INSURED ID#** _____

Signature of Parent/Guardian