

# WESTLAKE CITY SCHOOL DISTRICT EMERGENCY MEDICAL AUTHORIZATION

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_

Address: \_\_\_\_\_ Email Address: \_\_\_\_\_

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authorization, when parents cannot be contacted.

Print Full Name	Home Phone	Work Phone	Cell Phone
Mother:	(    )	(    )	(    )
Father:	(    )	(    )	(    )
Other Responsible Person (Relationship)	(    )	(    )	(    )
Other Responsible Person (Relationship)	(    )	(    )	(    )

## PART 1 or PART 2 MUST BE COMPLETED

### *PART 1 – TO GRANT CONSENT*

**In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for: (1)** the administration of any treatment deemed necessary by:

Dr. \_\_\_\_\_, PHONE (\_\_\_\_\_) \_\_\_\_\_ (preferred physician),

Dr. \_\_\_\_\_, PHONE (\_\_\_\_\_) \_\_\_\_\_ (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:     St. John Westshore     Fairview     Lakewood

If the emergency is such that your child needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

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

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Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

## If You Completed Part 1 Above – Do NOT Complete Part 2

### *PART 2 – REFUSAL TO CONSENT*

**In the event reasonable attempts to contact me at the above numbers have been unsuccessful, 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:**

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Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

***EMERGENCY RELEASE AUTHORIZATION (on back)***