

TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

EMERGENCY MEDICAL AUTHORIZATION

Mentor Public Schools, 6451 Center Street, Mentor, Ohio (440-255-4444)

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.

Student Name _____ Date of Birth _____ Home Phone _____

Address _____ City _____ Zip Code _____

School _____ Homeroom Teacher _____ Grade _____

Parent or Guardian (Residential) _____ Student lives with _____

Mother _____ Daytime Phone _____ Cell _____ Pager _____

Father _____ Daytime Phone _____ Cell _____ Pager _____

Mother's place of employment _____ Father's place of employment _____

In situations where the parent cannot be reached the student may be released to the following:

Name of relative or childcare provider _____ Relationship _____

Address _____ Daytime Phone _____ Cell _____ Pager _____

Other Name _____ Daytime Phone _____ Cell _____ Pager _____

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

Allergies _____

Health Concerns _____

Medications _____

Revised 06/09

REVERSE SIDE MUST BE COMPLETED AND SIGNED

The student may also be released to the following:

Name _____ Relationship _____ Phone _____ Cell _____

Name _____ Relationship _____ Phone _____ Cell _____

Name _____ Relationship _____ Phone _____ Cell _____

**PART I OR PART II MUST BE COMPLETED AND SIGNED
PART I - TO GRANT CONSENT**

I hereby give my consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____ Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

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 the above-named doctor 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.

Signature of custodial/residential parent _____

Address _____ Date _____

**DO NOT COMPLETE PART II IF YOU HAVE 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 the following action:

Signature of custodial/residential parent _____ Address _____ Date _____