EMERGENCY MEDICAL AUTHORIZATION

Northern Local School District

5341 F1
1/30/2013

_____ Sheridan HS _____ Sheridan MS _____ Glenford _____ Somerset _____ Thornville

Students Name (on line above) | Date of Birth | Grade | Box No. (for mailing purposes)

(Street Address) | (City) | (State) | (Zip)

Non-Residential Parent: _____

(Street Address) | (City) | (State) | (Zip)

PURPOSE: To enable parent and guardian to authorize the provision of emergency treatment for children who become ill or injured, when the guardian cannot be reached. **This is a state requirement**

CONTACT INFO: MUST BE COMPLETED AND UPDATED WITH CHANGES (and for Student Pick-Up)

Mother's Name Step__ Foster___ | Home Phone | Cell Phone | Workplace Phone

Mother's Email Address: _____

Father's Name Step__ Foster___ | Home Phone | Cell Phone | Workplace Phone

Father's Email Address: _____

Please complete at least 2 more contacts if parent cannot be reached:

Name Relationship _____ Phone | Name Relationship _____ Phone

Name Relationship _____ Phone | Name Relationship _____ Phone

PART I-CONSENT FOR TREATMENT

After being unsuccessful in reaching a number above, **I hereby give my consent** for:
(1)administration of any treatment deemed necessary by _____ Preferred Physician _____ Phone

or by _____ Preferred Dentist _____ Phone or by _____ Counseling Center/Counselor _____ Phone

or in event the designated preferred practitioner is not available, by another licensed physician or dentist and _____ Preferred Hospital or any hospital reasonably accessible. This authorization does not cover surgery unless the medical opinion of two(2) other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. This authorization also allows for transport per EMS services.

Note: This info needed for emergency personnel, please provide each school year.

List Medication	***List Allergies***	***Physical Impairments***	***Other***
1.	1.	1.	1.
2.	2.	2.	2.

X _____ _____
Parent or Guardian Signature (on line above) Date (on line above)

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 illness or injury requiring treatment, I wish the school authorities to take no action or to:

1.

Parent or Guardian Signature | Date