Defiance County Early Intervention Program

EMERGENCY MEDICAL AUTHORIZATION FORM

PART I or II MUST BE COMPLETED

Part I - **To Grant Consent**

I hereby give consent for the following medical 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 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.

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

_____

_____

X_____ *Address:* _____

Signature of Parent/Guardian

Date: _____ _____

Part II - **Refusal To Consent**

I **DO NO**T give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the HMG authorities to take the following action:

_____

_____

X_____ *Address:* _____

Signature of Parent/Guardian

Date: _____ _____

notes: _____

_____

_____

_____