Defiance DD
County Board of Developmental Disabilities
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Emergency Medical Authorization Form

Student Name: _____
Address: _____
Phone Number: _____ Cell Phone Number: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mothers Name		Phone Number	
Father's Name		Phone Number	
Other's Name		Phone Number	

Name of Relative or Childcare Provider:

Name		Relationship	
Address		Phone Number	

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 Number	
Dentist		Phone Number	
Medial Specialist		Phone Number	
Local Hospital		Phone Number	

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:

_____
_____

Signature of Parent/Guardian Date

Address

Part II- Refusal to Consent

I DO NOT give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the school authorities to take the following action:

_____
_____

Signature of Parent/Guardian Date

Address