COLUMBIANA EXEMPTED VILLAGE SCHOOLS

PERSONNEL EMERGENCY MEDICAL AUTHORIZATION PERMIT

_____ _____ _____ _____

Name (print or type) Date of birth Home phone Cell phone

_____

Street Address (including Unit # or P.O. Box if applicable) City State Zip Code

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention if necessary, I authorize the individuals listed below to act on my behalf.

This authorization is valid until such time as I withdraw the authorization.

Authorized Person _____
Telephone Number(s) _____
(*home)* *(cell)* *(work)*

Authorized Person _____
Telephone Number(s) _____
(*home)* *(cell)* *(work)*

Doctor Preferred _____ Telephone _____
Address _____

Dentist Preferred _____ Telephone _____
Address _____

Emergency Medical Facility/Hospital Preferred _____
Address _____

Medical Insurance Company _____ ID# _____
Address _____

IMPORTANT MEDICAL INFORMATION

Allergies _____

Current Medications or Treatments _____
_____
_____

Previous Surgeries or Hospital Confinements _____
_____
_____

Other information pertinent to an emergency situation _____
_____
_____

_____ _____
SIGNATURE DATE

To be filed in the office of the Building Principal. Copy to be filed in the office of the Superintendent. **12/27/2010**