Adena Local Schools
Emergency Medical Authorization

Name _____ Date of Birth: _____ M/F

Address _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT PERSONS:

Name _____ Relationship _____

Home/Work Phone: _____ Cell Phone: _____

Name _____ Relationship _____

Home/Work Phone: _____ Cell Phone: _____

Name _____ Relationship _____

Home/Work Phone: _____ Cell Phone: _____

EMERGENCY TREATMENT – <u>PART I OR II MUST BE COMPLETED And SIGNED</u>

Part I – To GRANT Consent:

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

Doctor: _____ City: _____ Phone #: _____
Dentist: _____ City: _____ Phone #: _____
Preferred Hospital: _____ City: _____ Phone #: _____

In the event I am unconscious or unable to communicate, I hereby give my consent for:

1 – Administration of any treatment deemed necessary by the above named doctor, or if the preferred doctor is not available, by another licensed physician or dentist.

2 – Transfer to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two (2) licensed physicians or dentist, concurring in the necessary of surgery, are obtained prior to the performance of such surgery.

Please list any medical facts or conditions that a physician should be alerted to. This includes medications taken, allergies, physical impairments and contact lenses.

Allergies:_____

Current Medications: _____

Other physical/medical conditions: _____

Signature: _____ Date: _____

Part II – REFUSAL of Consent:

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

Signature: _____ Date: _____