

MIAMI COUNTY EDUCATIONAL SERVICE CENTER  
2000 WEST STANFIELD ROAD  
TROY, OHIO 45373

EMPLOYEE EMERGENCY MEDICAL AUTHORIZATION

School Year: \_\_\_\_\_

**EMPLOYEE INFORMATION** *(Please print)*

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_  
School Bldg: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

**EMERGENCY CONTACTS**

Emergency Contact #1 \_\_\_\_\_

Relationship: \_\_\_\_\_  
Daytime Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_

Relationship: \_\_\_\_\_  
Daytime Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_

**MEDICAL CARE PROVIDERS:**

Physician: \_\_\_\_\_  
Dentist: \_\_\_\_\_  
Medical Specialist: \_\_\_\_\_  
Local Hospital: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Emergency Room Phone: (\_\_\_\_) \_\_\_\_\_

**GRANT CONSENT**

In the event reasonable attempts have been unsuccessful to contact the above person(s), I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer to any hospital reasonably accessible.

Medical History/Conditions: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE KEEP THIS INFORMATION CURRENT. COMPLETE A NEW FORM WHEN A CHANGE OCCURS.**