EMERGENCY MEDICAL AUTHORIZATION

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

Student's Name:_____Birth Date:_____Grade:_____

Street Address:_____

Mailing Address: (if applicable; e.g. - P.O. Box #)_____

City/State/Zip:_____Date of Last Tetanus:_____

Student resides with (circle all that apply) Mother Father Step-parent Guardian Other:_____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd). If more names are needed, add to the back of this sheet. **Contacts listed on this sheet are people who may pick my child up from school.**

	Mother:	Home #	Work #	Cell #
	Father:	Home #	Work #	Cell #
	Step-parent:	Home #	Work #	Cell #
	Guardian:	Home #	Work #	Cell #
	Alternate:	Home #	Work #	Cell #

(See back of sheet for more Alternate contacts)

COMPLETE ONLY ONE OF THE FOLLOWING: I. Consent for Treatment **OR** II. Refusal to Consent

I. CONSENT FOR TREATMENT:

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

Preferred Physician:_____
Office #_____

Preferred Dentist:_____
Office #_____

Medical Specialist:_____
Office #_____

Preferred Hospital:_____
ER #_____

AND...

II. REFUSAL TO CONSENT:

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

_____
_____
_____

_____
Parent/Guardian Signature Date

Address:_____
_____

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 the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; (2) the transfer of the child to any hospital reasonably accessible; and (3) sharing medical information with school staff that would need to know for continuity of care for my child.

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.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

_____

Parent/Guardian Signature: _____Date:_____

	Alternate:	Home #	Work #	Cell #
	Alternate:	Home #	Work #	Cell #
	Alternate:	Home #	Work #	Cell #

Section 3313.64 - AS USED IN THIS SECTION, “PARENT” MEANS EITHER PARENT, UNLESS THE PARENTS ARE SEPARATED OR DIVORCED, IN WHICH CASE “PARENT” MEANS THE PARENT WITH LEGAL CUSTODY OF THE CHILD. IF NEITHER PARENT HAS LEGAL CUSTODY OF THE CHILD, “PARENT” MEANS THE PERSON OR GOVERNMENT AGENCY WITH LEGAL CUSTODY OR PERMANENT CUSTODY.

ACKNOWLEDGMENT OF RISK

Risk in sports, as in any activity, are real. Participation has the potential for causing injury to individuals. Proper conditioning, instruction, and equipment can greatly reduce your child's chance of injury. The coaches of Indian Valley will do their best to prevent, protect, and treat injuries to your child.

We acknowledge the fact that risk of injuries is present in the sports program offered in the Indian Valley Schools. We grant our child permission to assume these risks while participating in sports. We assume these risks with the understanding that the Indian Valley Schools will do everything in their power to reduce the injury potential to our child.

Student Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____