BUCKEYE CAREER CENTER

STAFF EMERGENCY MEDICAL AUTHORIZATION FORM

Please *print* using blue or black ink.

_____ _____

Staff Name Career Technical Program

_____ _____

Address Phone Number

_____ _____

Date of Birth Social Security Number

WHO TO CONTACT:

_____ _____

Spouse Daytime Phone

_____ _____

Other Name Daytime Phone

_____

Name of Relative

Address _____ Phone _____ Relationship _____

Purpose – To authorize the provision of emergency medical treatment for employee who becomes ill or injured while under school authority.

Doctor _____ Daytime Phone _____

Dentist _____ Daytime Phone _____

Medical Specialist _____ Daytime Phone _____

Local Hospital _____ Daytime Phone _____

PART 1 or PART 2 MUST BE COMPLETED

PART 1 - TO GRANT CONSENT

I hereby give my consent for the administration of any treatment deemed necessary by the listed doctor, dentist, or medical specialist, in the event the preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer to the above hospital or any hospital reasonably accessible.

This authorization does not cover surgery unless pre-authorization has been approved by our insurance carrier.

Facts concerning my medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____

Date_____ Signature of staff member _____

Address _____

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DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1

Part 2 REFUSAL TO CONSENT

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

_____

_____

Date_____ Signature of staff member __ _____

Address _____