BUCKEYE CAREER CENTER

EMERGENCY MEDICAL AUTHORIZATION FORM

Please *print* using blue or black ink.

Student's Name _____ BCC Program _____

Address _____ Home School District _____

City, State, Zip _____ Home Phone # _____

Date of Birth _____

Student lives with(check one): ____ Both parents ____ Mother ____ Father ____ Other: _____

Identify residential and/or non-residential parent or guardian

Mother _____ Daytime phone _____ Cell phone _____

E-mail address _____

Father _____ Daytime phone _____ Cell phone _____

E-mail address _____

Other name _____ Daytime phone _____ Cell phone _____

Name of relative or child care provider _____

Address _____ Phone _____ Relationship _____

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.

Doctor _____ **Phone** _____

Dentist _____ **Phone** _____

Medical Specialist _____ **Phone** _____

Local Hospital _____

PART 1 or PART 2 MUST BE COMPLETED

PART 1 - TO GRANT CONSENT

In the event reasonable attempts to reach me or other parent or guardian have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the listed doctor, dentist, or medical specialist, or in the event the designated preferred practitioner is not available, by a licensed physician or dentist; and (2) the transfer of the child to the above hospital reasonably accessible.

This authorization does not cover surgery unless the medical opinions of two other licensed physicians or dentists, concurring with the necessity for such surgery, are obtained prior to the performance of such surgery.

State facts related to any medical history or diagnosis including allergies, all medications taken at home or school, and any physical impairments to which a physician or school nurse should be alerted. This information may be shared with staff on a need-to-know basis. _____

_____

_____

Date_____ Signature of parent _____

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 parent _____

Address _____