

**EMERGENCY MEDICAL AUTHORIZATION**

**HILLIARD CITY  
SCHOOL DISTRICT**

Student Name (Last/First) \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Parents Email \_\_\_\_\_

Purpose - To enable parents to authorize emergency treatment for children who becomes ill or injured while under school authority, when parents can not be reached

**PART I OR PART II MUST BE COMPLETE**

**PART I (TO GRANT REQUEST)**

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_

other parent at \_\_\_\_\_ (phone number) have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred physician) or Dr. \_\_\_\_\_ (preferred dentist) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and;

(2) the transfer of the child to \_\_\_\_\_ (preferred hospital) or and hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two licensed physician or dentist, concurring in necessity for surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medication being taken, and any other impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

**PART 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 treatment, I wish the school authorities to take no action or to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

Student's full name \_\_\_\_\_  
Preferred name/nickname \_\_\_\_\_ Phone \_\_\_\_\_  
Student's address \_\_\_\_\_  
Parent/Guardian's name(s) \_\_\_\_\_  
Address if different than student's \_\_\_\_\_  
Parent/Guardian's phone Home \_\_\_\_\_ Work \_\_\_\_\_  
Student's date of birth \_\_\_\_\_ SS# \_\_\_\_\_

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Insurance company name \_\_\_\_\_  
Insurance company address \_\_\_\_\_

(Photocopy of card may be attached if you wish)

Policyholder's name \_\_\_\_\_ Policy # \_\_\_\_\_

Personal Physician \_\_\_\_\_ Phone \_\_\_\_\_

Personal Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital of choice \_\_\_\_\_ Phone \_\_\_\_\_

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Student is presently taking the following medication(s) \_\_\_\_\_

Name of med and dose \_\_\_\_\_

Reason for taking medication \_\_\_\_\_

Date of last tetanus injection \_\_\_\_\_

Student is allergic to medication/insect bites etc. \_\_\_\_\_

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Student responds to the above in what manner \_\_\_\_\_

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Serious illness/injuries (include dates) \_\_\_\_\_

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Common/frequent symptoms:

Headaches \_\_\_\_\_

Earaches \_\_\_\_\_

Motion sickness \_\_\_\_\_

Constipation \_\_\_\_\_

Stomachaches/Indigestion \_\_\_\_\_

Sunburn \_\_\_\_\_

Fainting spells \_\_\_\_\_

Menstrual cramps \_\_\_\_\_

Colds, sore throats, allergies \_\_\_\_\_

Urinary problems \_\_\_\_\_

Joint pains \_\_\_\_\_

Rashes \_\_\_\_\_

The above symptom(s) are relieved by the following treatment: \_\_\_\_\_

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Student carries an inhaler for asthmatic condition \_\_\_\_\_

How many times per day does the student use the inhaler \_\_\_\_\_

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Student wears:

Glasses \_\_\_\_\_

Dental appliances \_\_\_\_\_

Contact lenses \_\_\_\_\_

Other prostheses \_\_\_\_\_

Students height \_\_\_\_\_

Students usual weight \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date

Parent/Guardian