Rootstown Local Schools

Emergency Medical Authorization

Student Name: _____ Grade: _____

Address: _____ City/Zip: _____ Birth Date: _____

Residential Parent or Guardian: _____Mother _____Father _____lives with both parents in same location

Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____
Parent or legal guardian in Active US Military: Yes ___ No___ If yes, Branch _____National Guard ____ Reserve_____

E-Mail: _____@_____ Phone # for Automated Alerts: _____

Father's Name: _____ Daytime Phone: _____ Cell Phone: _____
Parent or legal guardian in Active US Military: Yes ___ No___ If yes, Branch _____National Guard ____ Reserve_____

E-Mail: _____@_____ Phone# for Automated Alerts: _____

Emergency Contacts

Call Order:	Relationship:	Name:	Day Phone:	Home Phone:	Cell Phone:	Has Permission to pick Up?
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____	_____

Emergency Care Information

Preferred Physician: _____ Phone: _____ Fax: _____

Preferred Dentist: _____ Phone: _____ Fax: _____

Preferred Hospital: _____ Phone: _____ Fax: _____

Medical concerns, conditions, health considerations, and/or medications taken: _____

_____

Please sign #1 OR #2

#1 Consent

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 above-named medical professionals, or, in the event the designated practitioner is unavailable, by another licensed physician or dentist; and the transfer of the child to any hospital reasonably accessible. 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 performance of such surgery. In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all school personnel that interact with my child.

Parent/Guardian Signature: _____ ***Date***: _____

#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 emergency treatment, I wish the school authorities to take no action or to take the following action:
_____.

Parent/Guardian Signature: _____ ***Date:*** _____