COSHOCTON CITY SCHOOLS

1207 CAMBRIDGE ROAD • COSHOCTON, OHIO 43812

(PLEASE USE BALLPOINT PEN)

EMERGENCY MEDICAL AUTHORIZATION

Student's Social Security Number _____

Student's Name _____ Sex____

Student resides with (circle one) mother, father, other

Address of Student and Parent of residence: _____

_____

Birthdate _____ Home Phone _____

Check here if new address ☐

_____
School Attending

_____ _____
Grade Homeroom Number/Teacher

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. **Please complete Part I or Part II.**

PART I TO GRANT CONSENT (Include at least two phone numbers)

Father - Full Name	Home Phone	Place of Employment	Phone No.
Mother - Full Name	Home Phone	Place of Employment	Phone No.
Another Adult - Relation	Home Phone	Address	Relationship
Another Adult - Relation	Home Phone	Address	Relationship

In the event reasonable attempts to contact any of the above have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by:

Preferred Physician/Medical Specialist	Ofc. Phone	Preferred Dentist	Ofc. Phone

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:

_____ or any hospital reasonably accessible.
Preferred Hospital

This authorization does not cover major surgery, unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

_____

_____

Signature of parent or legal guardian giving consent: _____ Date _____

(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 emergency treatment, I wish the school authorities to either take no action or do the following:

_____

_____

_____

Signature of parent or legal guardian not giving consent: _____ Date _____

CCS 9/02