3313.712

EMERGENCY MEDICAL AUTHORIZATION

LUTHERAN SCHOOLS OF OHIO
School District

Student Name

Address

Telephone

St. John Nottingham Lutheran
School Attended

Purpose - To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

Part I or Part II must be completed
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 of the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably acceptable.

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

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

Date _____

Signature of Parent

Address

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 medical treatment, I wish the school authorities to take no action or to:

Date _____

Signature of Parent

Address