



East Dayton Christian School

**EMERGENCY MEDICAL AUTHORIZATION**  
**2017-2018**

Please **PRINT IN INK** or **TYPE** and complete all blanks.

**Name of Student** \_\_\_\_\_ Birthdate \_\_\_\_\_  
Homeroom Teacher \_\_\_\_\_ Room # \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

**Names of Parents/Guardians** \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip Code \_\_\_\_\_ School District \_\_\_\_\_ Email address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Siblings at EDCS Names/Grades** \_\_\_\_\_

**Place of Employment for Parents/Guardians:**

Father \_\_\_\_\_ Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Mother \_\_\_\_\_ Phone \_\_\_\_\_ Ext \_\_\_\_\_

**Authorized persons to assume responsibility for school dismissal and provisions of care when a parent/guardian cannot be reached:**

1. \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
2. \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**Family Physician or Pediatrician** \_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

**Family Dentist** \_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

**Local Hospital Preference** \_\_\_\_\_

Address \_\_\_\_\_  
Insurance that applies to child \_\_\_\_\_ Policy # \_\_\_\_\_

**Relevant medical factors including allergies** \_\_\_\_\_

**Medications** \_\_\_\_\_

**Physical Impairments** \_\_\_\_\_

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**COMPLETE BOTH SIDES**

**1. CONSENT FOR EMERGENCY MEDICAL TREATMENT**

In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give my/our consent for administration of any treatment deemed necessary by

Dr. \_\_\_\_\_ (preferred doctor) available, another doctor or dentist; and the transfer of the student to the above stated hospital or any hospital reasonable accessible. This authorization doesn't 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.

Signatures of Parents/Guardians \_\_\_\_\_

Date \_\_\_\_\_

**2. CONSENT FOR EMERGENCY TRANSPORTATION**

In the event my/our child needs to be transported by ambulance or emergency vehicle, I/we authorize transportation.

Signature of Parents/Guardians \_\_\_\_\_

Date \_\_\_\_\_

**3. REFUSAL TO CONSENT**

**NOTE** Do NOT complete Part 3 if you have completed Part 1.

I/We do not give my/our consent for emergency medical treatment of my/our child. In the event of illness or injury requiring emergency treatment, I/we wish the school authorities to take no action, or to \_\_\_\_\_

Signature of Parents/Guardians \_\_\_\_\_

Date \_\_\_\_\_