



East Dayton Christian School

EMERGENCY MEDICAL AUTHORIZATION
2019-2020

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 _____