Warrensville Heights City School District
4500 Warrensville Center Road
Warrensville Heights, Ohio 44128

WARRENSVILLE HEIGHTS City School District

2019-2020

EMERGENCY MEDICAL AUTHORIZATION FORM

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/guardians cannot be reached.*

☐ **Check here if any phone numbers have changed.**

Grade: _____ **D.O.B.:** _____

Student's Name: _____

Address: _____ **Apt. #:** _____
(An address change must be verified by providing immediately a new proof of residency to the Department of Pupil Services Office)

Mother's Name: _____ **Home Phone:** _____
Mother's Address: _____
Place of Employment: _____ **Work Phone:** _____
Cellular Phone: _____ **E-mail Address:** _____

Father's Name: _____ **Home Phone:** _____
Father's Address: _____
Place of Employment: _____ **Work Phone:** _____
Cellular Phone: _____ **E-mail Address:** _____

Please provide names and phone numbers of two (2) other emergency contacts if you cannot be reached.

Name: _____ **Phone:** _____ **Relationship:** _____
Name: _____ **Phone:** _____ **Relationship:** _____

PART I OR PART II MUST BE COMPLETED

Medical
Part I to Grant Consent
I hereby consent for the following medical care providers and local hospital to be called:

Doctor's Name: _____ **Phone #:** _____
Dentist's Name: _____ **Phone #:** _____
Preferred Hospital: _____ **Phone #:** _____

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 to above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Signature: _____ Date: _____

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

_____

_____

Attach major medical concerns

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 take the following action:

_____

_____

_____

Date: _____ Signature of Parent/Guardian: _____

If you have other students in the district, please list their names, ages, grades, and the school they attend below:

Name: _____Age_____ Grade: _____ School: _____

Name: _____Age_____ Grade: _____ School: _____

Name: _____Age_____ Grade: _____ School: _____

Name: _____Age_____ Grade: _____ School: _____

Does the other parent have shared legal parental rights to student(s) records, to visit, or take the student out of school? Yes: _____ No: _____

If yes, court papers are presented, please note that the district assumes that both parents if listed have equal parental rights to student(s) and his/her record.

If no, Warrenville Heights City School District can only enforce with legal documentation.

Does the school district have permission to contact you by text messaging_____ yes _____no ?

Who is your cell carrier provider _____ ?

Signature: _____ Date: _____
(Parent/Guardian)