Emergency Medical Authorization

Student Information

Student Name:	Student attends Aldersgate Christian Academy in the Cincinnati Public School District, but resides in:
Address:	
Home Phone:	(school district)
Emergency Contact:	
Emergency Phone:	

Purpose of this form:
To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part 1 **OR** Part 2 must be completed.

Part 1 (To Grant Permission)		
In the event reasonable attempts to contact me at (phone number)		
or (other parent/guardian)		
at (phone number)		
have been unsuccessful, I hereby give my consent for: 1. the administration of any treatment deemed necessary by (preferred physician) or (preferred dentist)		
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 (preferred hospital)		
or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, 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)	(parent/guardian signature)	(address)

DO NOT COMPLETE PART II IF YOU COMPLETED PART I.

Part 2 (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 no action or to:		
(date)	(parent/guardian signature)	(address)