

NORDONIA HILLS CITY SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT NAME _____

HR TEACHER _____ /

DATE _____

STREET ADDRESS _____

GRADE _____ /

BIRTHDATE _____

CITY _____

ZIP CODE _____

SCHOOL ATTENDING _____

RESIDENTIAL PARENT OR GUARDIAN:

HOME PHONE: _____

Mother _____ /

work _____ /

cell _____

Father _____ /

work _____ /

cell _____

Other name _____ /

work _____ /

cell _____

IF PARENT OR GUARDIAN IS UNAVAILABLE, NAME OF RELATIVE OR DESIGNATED CHILDCARE PROVIDER TO CONTACT:

1. Name _____ /

home _____ /

cell _____

2. Name _____ /

home _____ /

cell _____

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MEDICAL ALERT INFORMATION

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

CONSENT

PLEASE COMPLETE EITHER PART I or PART II ON THE BACK OF THIS FORM.

PART I is completed to grant consent for emergency treatment.

PART II is completed to refuse consent.

