

Hilliard City School District
Hilliard Darby High School
EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: To enable parents to authorize emergency medical treatment for children who become ill or injured while under school authority, when parents cannot be reached. You must complete Part I OR Part II.

PART I (To Grant Request)

In the event that reasonable attempts to contact me or the other parent have been unsuccessful, I hereby give my consent 1) for the administration of any treatment deemed necessary by our preferred physician or dentist, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and 2) for the transfer of the our 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.

Student's Name: _____

Parent's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Other Parent's Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Preferred Doctor: _____ Office Phone: _____

Preferred Dentist: _____ Office Phone: _____

Preferred Hospital: _____

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

Parent's Signature: _____ Date: _____

Address: _____

PART II (Refusal to Consent to Treatment)
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take no action, or to:

Parent's Signature: _____ Date: _____

Address: _____