NORTHWEST LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

_________________________________ School
_____________________ Gender

_________________________________ Student Name
_____________________ Date of Birth

_________________________________ Student ID #
__________ Grade
__________ Homeroom/Advisory
_____________________ Telephone Number

_________________________________ Address
__________ City
__________ State
_____________________ Zip

Student Lives with (check one) ___Mother ___Father ___Both ___ Guardian ___Foster

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the school's authority, when parents or guardians cannot be reached. I understand that the NWLSD may disclose medical information to all staff members who will be in contact with my child.

A. Residential Parent/Guardian Name ☐Mr. ☐Mrs. ☐Ms. ____

Home Phone # __________________________ Cell Phone # _____________________________

Place of Employment _______________________________________ Work Phone # _______________________

Other Parent Name ☐Mr. ☐Mrs. ☐Ms. ________________________________ Relationship to Student _______________

Home Phone # _________________________ Cell Phone # _____________________________

Address (If different than student) ____

Place of Employment ____ Work Phone # ______________________

Other Emergency Contact ☐Mr. ☐Mrs. ☐Ms. ____________________________ Relationship to Student _______________

Home Phone # ________________________ Cell Phone # _____________________________

Other Emergency Contact ☐Mr. ☐Mrs. ☐Ms. ____________________________ Relationship to Student _______________

Home Phone # ________________________ Cell Phone # _____________________________

B. Name of Childcare/Daycare Provider ____

Address ____ Phone # ____________________________

************PART I OR PART II MUST BE COMPLETED AND SIGNED************

PART I MUST BE COMPLETED TO GRANT CONSENT: I hereby give consent for the following medical care providers/local hospital to be called

Doctor's Name _____________________________________ Phone # ___________________________________

Dentist's Name _____________________________________ Phone # ___________________________________

Local 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 by above-named doctor, 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 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 prior to the performance of such surgery.

Date ____________________ Signature of Parent/Guardian ____

PART II – REFUSAL TO CONSENT – DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I DO NOT give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: ____

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Date ____________________ Signature of Parent/Guardian ____

Revised 03/14