

EMERGENCY MEDICAL FORM

Lucas Athletic Department
5 First Ave. Lucas, OH 44843

Student's Name: _____ Social Security # _____ - _____ - _____

Address: _____
(street) (city) (state) (zip code)

Home Phone (____) _____ - _____ Student's Birthday: _____ - _____ - _____
(month) (day) (year)

Grade _____ Age: _____

Purpose is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Richland County S.R.P. authority, when parents or guardians cannot be reached.

Residential Parent/Guardian:

Mother's Name: _____ Daytime Phone (____) _____ - _____

Cell Phone (____) _____ - _____

Father's Name: _____ Daytime Phone (____) _____ - _____

Cell Phone (____) _____ - _____

Other's Name: _____ Daytime Phone (____) _____ - _____

Relation: _____ Cell Phone (____) _____ - _____

Name of student's regular care provider: _____

Address: _____ Ph: (____) _____ - _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician and school employees should be alerted to protect the student's health and safety:

COMPLETE ONLY PART I or PART II

Part I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Phone (____) _____ - _____

Dentist: _____ Phone (____) _____ - _____

Medical Specialist: _____ Phone (____) _____ - _____

Local Hospital: _____ Emergency Room 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 practioner 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 _____
Address _____

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 _____
Address _____