BLANCHESTER LOCAL SCHOOL ATHLETIC DEPARTMENT Date _____

Emergency Medical Form

Purpose: To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school authority when parents or guardians can not be reached.

Student Name _____

Address _____

Grade Level _____

City/State/Zip _____

Date of Birth _____

Home Phone # _____

Residential Parent or Guardian:

Mother's Name _____ Cell or Daytime Phone _____

Father's Name _____ Cell or Daytime Phone _____

Student Lives with _____ Cell or Daytime Phone _____

Please list at least 2 (two) persons who you wish to be called, if you can not be reached:

_____ _____ _____

Name Relationship to student Phone number

_____ _____ _____

Name Relationship to student Phone number

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT: I hereby give consent for the following medical providers and local hospital to be called:

Doctor _____ Phone Number _____

Dentist _____ Phone Number _____

Local Hospital _____ Emergency Room Phone Number _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give 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.
(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.

Medical problems or specials needs: Diabetes ___ Asthma ___ Seizures ___ Physical Limitations ___
Emotional Problems ___ Medication/Food/Bee Stings/Other Allergies ___ Severe Allergic Reaction ___ Other conditions___
Please describe any of the conditions marked above _____

Current medication(s):_____

Signature of
Parent/Guardian_____Printed Name_____Date_____

PART II - REFUSAL TO CONSENT

I **DO NOT** give 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:

_____

Signature of
Parent/Guardian_____Printed Name_____Date _____