East Richland Christian Schools

67888 Friends Church Road
St. Clairsville, OH 43950
Phone (740) 695-2005
Fax (740) 296-5219
ercs@comcast.net
www.eastrichland.org

EMERGENCY MEDICAL AUTHORIZATION FORM

East Richland Christian Schools
School District

_____
Student Name

_____
Address

_____

_____
Phone

Purpose: to enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Part I or Part II MUST BE COMPLETED
PART I **(**TO GRANT REQUEST)

In the event reasonable attempts to contact me at _____ (phone #) or _____ (other parent) at _____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred Physician) or by Dr. _____ (preferred Dentist), 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 _____ (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.

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

_____

_____

Date: _____Parent's Signature: _____

Parent's Address: _____

****

DO NOT COMPLETE PART II IF YOU COMPLETED PART I
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 medical treatment, I wish the school authorities to take no action or to:

_____

Date: _____ Parent's Signature: _____

Parent's Address: _____