CUYAHOGA VALLEY CAREER CENTER

STUDENT EMERGENCY MEDICAL AUTHORIZATION

Associate School _____ Student Name _____

Address _____

CVCC Program Name _____ _____ Zip _____

_____ Telephone ( ) _____

Date of Birth (MM/DD/YY) _____

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

Residential Parent or Guardian:

Mother's Name _____ Home Phone ( ) _____

Address if different than above: _____ Cell Phone ( ) _____

_____ Work Phone ( ) _____

Father's Name _____ Home Phone ( ) _____

Address if different than above: _____ Cell Phone ( ) _____

_____ Work Phone ( ) _____

Other's Name _____ Home Phone ( ) _____

Address if different than above: _____ Cell Phone ( ) _____

_____ Work Phone ( ) _____

Name of Relative or Childcare Provider:

_____ Relationship _____

Address _____ Home Phone ( ) _____

_____ Cell Phone ( ) _____

Work Phone ( ) _____

You can authorize such emergency medical treatment for your child by completing Part I. **By completing Part II, you do NOT give your consent for emergency medical treatment.**

PART I OR II MUST BE COMPLETED

(See reverse side)

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 doctors, 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. If a specific hospital is designated, other than the ones served by the local emergency service unit, then the Parent or Guardian will accept financial responsiblity. (The Brecksville Emergency Unit provides free service to Parma Hospital, Marymount Hospital, Sagamore Hills Ambulatory Center and Marymount South Ambulatory Center.)

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

_____

_____

_____

Date_____ Signature of Parent/Guardian _____

Address _____

_____ Zip_____

PART II: REFUSAL TO CONSENT

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

_____

_____

Date_____ Signature of Parent/Guardian _____

Address _____

_____ Zip_____