First Name:	Date of Birth:

Fairview Park City School District
21620 Mastick Rd., Fairview Park, OH 44126
p: 440.331.5500 f: 440.356.3545
www.fairviewparkschools.org

Last Name:	Graduation Year:

Student Number:

Document Type:

EMERGENCY MEDICAL AUTHORIZATION FORM /LOCAL EMERGENCY RELEASE AUTHORIZATION

Student Name:_____ **Grade** _____

Address:_____

_____ **Phone**: (_____) _____

In the event reasonable attempts to contact me have been unsuccessful, **I hereby authorize (1)** the provision of emergency treatment for my child if he/she becomes ill or injured under school authority **and (2)** in case of a national/local emergency, my child may be released to any of the following individuals:

RESIDENTIAL PARENT OR GUARDIAN

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

email address: _____ Cell Phone: (_____) _____

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

email address: _____ Cell Phone: (_____) _____

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

Relationship: _____ Cell Phone: (_____) _____

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

Relationship:_____ Cell Phone: (_____) _____

***Any non-custodial adult will require photo I.D. before the child is released.**
***Without this form on file, children will only be released to parent or guardian.**
***Students 18 years and older may check themselves out.**

PART I OR PART 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:_____ 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 the above named physicians, 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.

Please list below facts concerning the child's medical history, including allergies, medications being taken, including those received for treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and any physical impairments to which a physician should be alerted. I give permission for this information to be shared with the Fairview Park Schools Staff involved with my child's educational program.

_____

_____

_____

_____

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:_____