

Japanese Language School of Cleveland

1857 South Green Road., South Euclid, Ohio

EMERGENCY MEDICAL AUTHORIZATION

Student: _____ Birthday: ____ / ____ / ____

 Last First

Parent(s)/Guardian: _____ Address: _____

Home Phone: (____) _____ Work, Cell Phone: (____) _____

Emergency Contacts

In case of emergency please contact (Give two names and relationship(s))

Name: _____ Telephone: (____) _____

Name: _____ Telephone: (____) _____

(Please complete Parts I or II and return without delay)

The purpose of this form is to make it possible for parents and guardians to authorize the provision of emergency treatment to children who become ill or injured while under school authority, when the parents or guardians can not be reached for the purpose of giving consent for such treatment. Such authority is necessary to overcome legal obstacles to the provision of such treatment when all reasonable attempts to reach parents or guardians have failed. You can authorize such emergency medical treatment for your child by completing this form.

Part I TO GRANT CONSENT, THIS SECTION MUST BE COMPLETED

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 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 reasonable 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.

Signature of parent /Guardian: _____ Date: _____

The following information is needed by any hospital or practitioner not having access to the student's medical history.

Allergies: _____ Medication being taken: _____

Date of last tetanus: ____ / ____ / ____ Physical impairments (Heart, Epilepsy, etc.): _____

Other pertinent facts to which physician should be alerted: _____

Signature of parent /Guardian: _____ Date: _____

Part II REFUSAL TO GRANT CONSENT

I, _____ of _____ am the _____

(Your name) (Your address) (Parent or legal guardian)

of _____, a minor, of _____

(Student's name) (Student's address)

who attends school at the Japanese Language School of Cleveland of 1857 South Green Road., South Euclid, Ohio.

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:

Signature of parent /Guardian: _____ Date: _____