OHSVCA EMERGENCY MEDICAL AUTHORIZATION

Name________________________________Phone______________________

Address____

In signing this authorization form, I certify that my OHSAA Physical form is current and on file at my home school district.

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

PART 1 OR PART 2 MUST BE COMPLETED

Part 1: To Grant Consent:

Mother's Name_____________________________ Work Phone_____________
Father's Name_____________________________ Work Phone_____________
Address___________________________________ Home Phone____________
Responsible Party_______________________ Insurance Co.______________

Name of relative or neighbor ________________________________
Relationship______________ who may be notified

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 a 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 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of the 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____

Part 2: 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 medical treatment, I wish the OHSVCA to take no action or to:

Date_______________
Signature of Parent / Guardian____