

ST. JOHN LUTHERAN CHURCH, WILLISTON, OHIO
EMERGENCY MEDICAL AUTHORIZATION FORM

Grade _____

Student's Name _____ Date of Birth _____

Student's Address _____

Home Phone _____ Cell Phone _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under the supervision at St. John Lutheran Church.

Mother's Name _____ Home Phone _____ Work _____

Cell Phone _____

Father's Name _____ Home Phone _____ Work _____

Cell Phone _____

Name of Relative or Childcare Provider _____ Relationship _____

Address _____ Home Phone _____

PART I OR PART II MUST BE COMPLETED

Part I: To Grant consent

I hereby give consent for the following medical care providers:

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above-named doctor/ dentist, or in the event the designated preferred physician/ dentist is not available, by another licensed physician/ dentist.

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 physical impairments to which a physician should be alerted: _____

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 church authorities to take the following action: _____

Date _____ Signature of parent/guardian _____

Address _____