

Independence High School Music Department
Spring Break Trip 2013
Return form by March 20, 2013

5341 F1
8760 F1

INDEPENDENCE LOCAL SCHOOLS
CUYAHOGA COUNTY • INDEPENDENCE, OHIO 44131

EMERGENCY MEDICAL AUTHORIZATION

School: IHS School Year: 2012-2013 Student Name: _____

Grade: _____ Address: _____ Telephone: []
Independence, Ohio 44131

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 : _____ Daytime Phone: []

Cell# and/or Pager#: [] E-Mail (optional): _____

Father's Name: _____ Daytime Phone: []

Cell# and/or Pager#: [] E-Mail (optional): _____

Other's Name _____ Daytime Phone: [] Cell# and/or Pager#: []

Name of Relative or Childcare Provider

_____ Relationship: _____

Address: _____ Daytime Phone: []

Part I - OR - II Must Be Completed

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 [] Hospital/ER 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. 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:

Signature of Parent/Guardian _____ Date _____

Address _____ Independence, Ohio 44131

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:

Signature of Parent/Guardian _____ Date _____

Address _____ Independence, Ohio 44131