GROVE CITY CHRISTIAN SCHOOL
EMERGENCY MEDICAL AUTHORIZATION FORM

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.

Student's Name _____ Grade _____

PART 1 – Consent
I hereby give consent for the following medical providers and local hospital to be called:
Doctor _____ 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 doctor, or in the event the designated preferred practitioner is not available, by another license 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 such surgery.
Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted, I have listed below:
_____
_____
_____

Signature of Parent or Guardian _____ Date _____

DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1

PART 2 – Refusal to Consent
I do **NOT** give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:
_____
_____
_____

Signature of Parent or Guardian _____ Date _____
Address _____