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 _________________________________________________________________