River View Local School District 2019-2020 School Year

EMERGENCY MEDICAL AUTHORIZATION

PLEASE PRINT USING BLUE OR BLACK INK

RVHS BAND	Student's Name		Grade:
	Student's Street Address	City	Date of Birth:
	Home Phone Student's Cell Phone (if applicable)		Home E-Mail Address (if applicable)

Purpose: The purpose of this form is 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.

Part I or Part II must be completed

PART I To Grant Consent

Mother's Name	Home Phone	Cell Phone	Place of Employment/Work Phone
Father's Name	Home Phone	Cell Phone	Place of Employment/Work Phone
Stepparent's Name (if applicable)	Home Phone	Cell Phone	Place of Employment/Work Phone
Relative Name / Relationship	Home Phone	Cell Phone	Place of Employment/Work Phone

In the event reasonable attempts to contact any of the above have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Preferred Physician	Office Phone	City
Preferred Dentist	Office Phone	City

Or in the event the designated preferred practitioner is not available the child will be transported to the nearest medical facility. This authorization does not cover major surgery unless the medical options of two (2) 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, medication being taken, and any physical impairments to which a physician should be alerted to are: (List or check "none")

☐ Check if "none", or list here _____

_____ / _____ _____

Signature of Parent or Guardian **relationship** **Date**

_____ _____ _____

Street address **City** **Zip**