



# CUYAHOGA VALLEY CAREER CENTER

## STUDENT EMERGENCY MEDICAL AUTHORIZATION

Associate School \_\_\_\_\_ Student Name \_\_\_\_\_

Address \_\_\_\_\_

CVCC Program Name \_\_\_\_\_ Zip \_\_\_\_\_

\_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_

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 \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address if different than above: \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address if different than above: \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Other's Name \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

Address if different than above: \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

### Name of Relative or Childcare Provider:

\_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

\_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

You can authorize such emergency medical treatment for your child by completing Part I. **By completing Part II, you do NOT give your consent for emergency medical treatment.**

**PART I OR II MUST BE COMPLETED**  
**(See reverse side)**

**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 ( ) \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room 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. If a specific hospital is designated, other than the ones served by the local emergency service unit, then the Parent or Guardian will accept financial responsibility. (The Brecksville Emergency Unit provides free service to Parma Hospital, Marymount Hospital, Sagamore Hills Ambulatory Center and Marymount South Ambulatory Center.)

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

**PART II: REFUSAL TO CONSENT**

I do NOT give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_