

**Please fill out this form & mail to: ATTN Tiffany Zents, 3400 Michigan Ave,
Cincinnati OH 45208**

EMERGENCY MEDICAL AUTHORIZATION

Ecumenical VBS: June 21-25, 2010

FAMILY NAME _____

CHILDREN'S FIRST NAMES _____

HOME ADDRESS _____ **PHONE** _____

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. (Part I or II must be completed)

PART I: TO GRANT CONSENT

In the event that reasonable attempts to contact _____ at (h) _____
or (w) _____ or _____ (*other parent or guardian*) at
(h) _____ or (w) _____ have been unsuccessful, I hereby give my
consent for the administration of any treatment deemed necessary by
Dr. _____ (*physician*) phone # _____ or
Dr. _____ (*dentist*) phone # _____, or in the event the
designated preferred practitioner is not available, by another licensed physician or dentist
and the transfer of the child to _____ (*preferred hospital*) or 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: _____

DATE _____ **SIGNATURE** _____
(Parent or Guardian)

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment to my child. In the event of illness or
injury requiring emergency treatment, I wish the school authorities to take no action or to:

DATE _____ **SIGNATURE** _____
(Parent or Guardian)