TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

EMERGENCY MEDICAL AUTHORIZATION

Mentor Public Schools, 6451 Center Street, Mentor, OH 44060 (440-255-4444)
Purpose: To enable parents/guardians to authorize emergency treatment for children who are ill/injured while under school authority when parents/guardians cannot be reached.

Student Name_____ School_____ Grade_____

Facts concerning the child's medical history including allergies, medications taken, and any physical impairments to which a physician should be alerted:

Allergies_____

Health Concerns_____

Medications_____

***ALL PARENTS PLEASE CHECK ONE: _____ I have updated our household information on the portal.**

https://campus.mentorschools.org/campus/portal/Mentor.jsp

_____I do not have access to a computer and need to have the forms sent home to me.

****ALL ELEMENTARY PARENTS (IF APPLICABLE) PLEASE FILL IN:**

_____ (Check) My child will use Mentor's WeCare after school at least some days.

Name and telephone number of Day Care Provider_____

PART I OR PART II MUST BE COMPLETED AND SIGNED

PART I – TO GRANT CONSENT

I hereby give my consent for the following Medical care 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 licensed 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 other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Signature of custodial/residential parent_____
Address_____Date_____

OR

PART II – REFUSAL TO CONSENT (*DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I*)

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

Signature of custodial/residential parent_____ Address_____ Date_____

(Please return this to the school by the first day of classes—thank you!)