OHIO MUSIC EDUCATION ASSOCIATION

Emergency Medical Authorization

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under OMEA authority, when parents or guardians cannot be reached.

Student Name ______________________ Phone # ______________________

Address ______________________ School District ______________________

______________________ School Attending ______________________

Birth Date __________ Sex M F Grade ______________________

Handicap or Disability ______________________

Please describe any special needs: ______________________

Residential Parent or Guardian

Mother ______________________ Day Ph # __________ Cell # __________

Email ______________________ Pager # __________

Father ______________________ Day Ph # __________ Cell # __________

Email ______________________ Pager # __________

Other Name ______________________ Day Ph # __________

Name of Relative or Childcare Provider ______________________

Address ______________________ Phone # __________

______________________ Relationship __________

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor ______________________ Phone # __________

Dentist ______________________ Phone # __________

Medical Specialist ______________________ Phone # __________

Hospital ______________________ Phone # __________

PLEASE COMPLETE PART I OR PART II—NOT BOTH

Part I—To Grant Consent

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 designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonbly accessible.

This authorization does not cover major surgery unless the medical opinion 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: ______________________

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Date __________ Parent or Guardian Signature ______________________

Address ______________________

Part II—Refusal to Consent

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 the OMEA authorities to take no action or to: ______________________

____

Date __________ Parent or Guardian Signature ______________________

Address ______________________