***Medical*** ***St. Andrew Athletic Association*** ***Medical***

***St. Andrew School***

***1899 McCoy Road***

***Columbus, Ohio 43220***

## *EMERGENCY MEDICAL AUTHORIZATION*

**Student Name** _____ **School** _____

**Address** _____ **Teacher** _____

**Telephone** _____

***Part I or II MUST BE COMPLETED***

In the event reasonable attempts to contact me at _____ (telephone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for:

(1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone) or Dr. _____ (preferred dentist) at _____ 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 _____ (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 altered _____

_____

***DATE*** _____

***Signature of Parent or Guardian*** _____

***ADDRESS*** _____

***DO NOT COMPLETE PART II IF YOU COMPLETED PART I***

***Part II (Refusal to Consent)***

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

***DATE*** _____

***Signature of Parent or Guardian*** _____

***ADDRESS*** _____

***Required by Ohio Revised Code 3373.712***