INDIA SUNDAY SCHOOL, AKRON, OHIO

EMERGENCY MEDICAL AUTHORIZATION (2020 – 2021)

Name of Student_____ Date of Birth _____

Parent's Name _____and _____

Alternate Person's Name _____ Phone No. _____ (If either parent cannot be reached)

In the event reasonable attempts to contact me at _____

or _____ have been unsuccessful, I hereby give my consent for

1. Administration of any medical treatment deemed necessary by Dr._____ (phone no._____) or, in the event the designated doctor is not available, by another licensed physician, and
2. Transfer of the child to _____or any other medical facility upon the discretion of the attending physician.

This authorization does not cover major surgery unless the opinion of two other licensed physicians, concurring in the necessity of such surgery, is obtained prior to the performance of such a surgery.

Please list any known allergies or medical problems:

_____

Parent or guardian's name_____

Signature of parent/guardian_____ Date_____