Brookville Local Schools

EMPLOYEE EMERGENCY MEDICAL AUTHORIZATION

Name: _____ DOB: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Building: _____

EMERGENCY MEDICAL CONTACT

List below the name of the person or persons to contact in case of a medical emergency:

Name _____ Telephone _____

Name _____ Telephone _____

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor _____ Telephone _____

Dentist _____ Telephone _____

Medical Specialist _____ Telephone _____

Local Hospital _____ Telephone _____

I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer 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.

Facts concerning my medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

_____

_____ _____
Employee's Signature Date

PART II - REFUSAL TO CONSENT (Do not complete Part II if you completed Part I)

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

_____

_____ _____
Employee's Signature Date

OFFICE – White Copy **NURSE** – Canary Copy

BV-35 Revised 05/2017