Autism Model School
3020 Tremainsville Rd. Toledo, OH 43613
(419)897-4400
www.AutismModelSchool.com

EMERGENCY MEDICAL AUTHORIZATION

Student Name: _____ SSN: _____

Current Grade Level (or equivalent): _____ Date of Birth: _____ Current Age: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____

Residential Parent(s)/Guardian(s): *Please list only those who reside with the student. If applicable, please **provide copies of custody paperwork**.*

Primary Guardian's Name: _____ Daytime Phone: _____

Relationship to Student: _____ Other Phone: _____

Secondary Guardian's Name: _____ Daytime Phone: _____

Relationship to Student: _____ Other Phone: _____

Person(s) to Contact in Case of Emergency: *List additional person(s) other than primary/secondary guardian(s).*

Primary Contact's Name: _____ Daytime Phone: _____

Relationship to Student: _____ Other Phone: _____

Secondary Contact's Name: _____ Daytime Phone: _____

Relationship to Student: _____ Other Phone: _____

Student's Health Information: *Select any of the below health conditions your child has been diagnosed with.*

____ Asthma	____ Respiratory Illness (Other than Asthma)	____ Heart Condition	____ Seizure Disorder
____ Muscular/Skeletal Disorder	____ Activity Limitation/Restriction	____ Urinary Tract Disorder	____ Hearing Disorder
____ Other Serious or Chronic Condition	____ Bee Sting Allergy	____ Other Severe Allergy(s)	____ Vision Disorder

Known food/drug allergies: _____

Preferred Medical Care Providers:

Physician Name: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital/Emergency Room: _____ City: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for:

a.) the administration of any treatment deemed necessary by the above named physician, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and
b.) 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. Be sure to include all facts concerning the child's medical history including allergies, medications being taken, and any physical impairment(s) to which a physician should be alerted within this form or necessary attachments.

_____ _____

Signature of Parent/ Guardian Date