BISHOP WATTERSON HIGH SCHOOL
99 E. Cooke Road • Columbus, Ohio 43214

BAND EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ Instrument _____

Street Address _____ City _____ Zip _____

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me, (parent/guardian name) _____ at (phone) _____ or (other parent/guardian) _____ at (phone) _____ have been unsuccessful, I hereby give my consent for: 1) The administration of any treatment deemed necessary by (physician) Dr. _____ at (phone) _____ or (dentist) Dr. _____ at (phone) _____ or in the event the designated preferred practitioner is not available, buy any other licensed physician or dentist: and 2) the transfer of the child to (hospital) _____ or any hospital reasonably accessible.

This authorization doe 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 alerted.

_____

_____

_____

Date _____ Signature of Parent or Guardian _____

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART 1

PART II (REFUSAL CONSENT)

I DO NOT give my consent for the emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, or to:

_____

_____

Date _____ Signature of Parent or Guardian _____