

**TOLLES CAREER & TECHNICAL CENTER**  
EMERGENCY INFORMATION & MEDICAL AUTHORIZATION



7877 US Highway 42 S  
Plain City, OH 43064  
(614) 873-4666  
www.tollestech.com

Student's Name \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone # (or primary guardian's #) \_\_\_\_\_  
Student's Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Mother or Guardian's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

e-mail address \_\_\_\_\_

Father or Guardian's Name \_\_\_\_\_ Home Phone # \_\_\_\_\_

Business Phone No. \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

e-mail address \_\_\_\_\_

List relatives or neighbors who will know your whereabouts and assume temporary care of your child if you cannot be reached:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Purpose of the following information:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Fill out only Part 1 or Part 2.**

**PART 1 – GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called: (list "any" if no preference)

Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Dentist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone ( ) \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) 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.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**PART 2 – REFUSAL TO CONSENT**

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

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_