MIAMI COUNTY EDUCATIONAL SERVICE CENTER
2000 WEST STANFIELD ROAD
TROY, OHIO 45373

EMPLOYEE EMERGENCY MEDICAL AUTHORIZATION

School Year: _____

EMPLOYEE INFORMATION *(Please print)*

Name: _____ Home Phone: (____) _____

Address: _____ Cell Phone: (____) _____

_____ Zip _____ Date of Birth: _____

School Bldg: _____

EMERGENCY CONTACTS

Emergency Contact #1 _____ Relationship: _____

Daytime Phone: (____) _____

Cell Phone: (____) _____

Emergency Contact #2 _____ Relationship: _____

Daytime Phone: (____) _____

Cell Phone: (____) _____

MEDICAL CARE PROVIDERS:

Physician: _____ Phone: (____) _____

Dentist: _____ Phone: (____) _____

Medical Specialist: _____ Phone: (____) _____

Local Hospital: _____ Emergency Room Phone: (____) _____

GRANT CONSENT

In the event reasonable attempts have been unsuccessful to contact the above person(s), I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, 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.

Medical History/Conditions: _____

Medications: _____

Allergies: _____

Signature: _____ Date: _____

PLEASE KEEP THIS INFORMATION CURRENT. COMPLETE A NEW FORM WHEN A CHANGE OCCURS.