



Summit County Youth Employment for Success Emergency Medical Authorization

Child Information			
Last Name	First	MI	Date of Birth
Address			
City, State, Zip Code	Phone Number	Message Number	
Purpose- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while on the job or on a field trip experience, when parents or guardians cannot be reached.			
Parent Information- <i>Medical Form must be completed</i>			
In the event of an emergency, please contact:			
_____	_____		
Parent Name	Phone Number		
_____	_____		
Other Parent of Guardian Name	Phone Number		
If you are unable to reach the above parent/guardian, I hereby give my consent for an authorized staff member to administer any treatment deemed necessary by transporting my child to:			
_____	_____	_____	
Preferred Physician Name	Address	Phone Number	
_____	_____	_____	
Preferred Dental Name	Address	Phone Number	
Any medical facility reasonably accessible:			
_____	_____	_____	
Preferred Hospital	Address	Phone Number	
This authorization does not cover a 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, any physical impairments to which a physician should be alerted: _____			

_____	_____		
Signature of Parent/Guardian	Date		

