WASHINGTON LOCAL SCHOOLS STAFF EMERGENCY MEDICAL AUTHORIZATION

Last Name _____ First _____ Middle _____ Birthdate _____

Address _____ Soc. Security # _____

City _____ State _____ Zip _____ Home Phone # _____

Place of Employment (Building) _____ Business Phone # _____

Preferred Physician (Name) _____ Phone # _____ Preferred Hospital _____ Phone # _____

Preferred Dentist (Name) _____ Phone # _____

If a medical emergency occurs which requires immediate attention, please contact:

Name _____ Phone _____ Relationship _____

(Over)

CONSENT:

I hereby give my consent for the administration of any treatment deemed necessary by my preferred physician, or, in the event my designated preferred practitioner is not available, by another licensed physician or dentist.

This authorization does not cover major surgery unless 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 my medical history, including allergies, medication being taken and other physical impairments to which a physician should be alerted:

_____

_____

Date _____ Signature of Employee _____

REFUSAL TO CONSENT:

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

_____

Date _____ Signature of Employee _____