Stow Parks and Recreation
330-689-5100
3760 Darrow Rd.,
Stow, OH 44224

EMERGENCY MEDICAL AUTHORIZATION

Purpose: to enable parents to authorize the emergency treatment for children who become ill or injured while under the Stow Parks authority when parents cannot be reached.

Fill out all portions of this form, sign, and submit to Stow Parks and Recreation. If submitting electronically, include electronic signature. Once complete, please email to parks@stow.oh.us.

CHILD INFORMATION

Child's Name:______________________________ Program:______________________

Address:______________________ City:______________ State:________ Zip Code:__________

Age:__________ Telephone: Home: ______________ Cell: ______________ Work: ______________

RESIDENTIAL PARENT OR GUARDIAN INFORMATION

Mother living with family? Yes________ No________ Father living with family? Yes________ No________

Mother Name:______________________________ Daytime Telephone:______________________

Father Name:______________________________ Daytime Telephone:______________________

Other Name:______________________________ Daytime Telephone:______________________

Name of relative or childcare provider:______________________________ Telephone:______________

Address:______________________ City:______________ State:________ Zip Code:__________

Relationship to Child:______________________________

Part I or Part II MUST BE COMPLETED

Part I (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:______________________________ Telephone:______________

Dentist:______________________________ Telephone:______________

Medical Specialist:______________________________ Telephone:______________

Local Hospital:______________________________ Telephone:______________

Urgent Care:______________________________ Telephone:______________

In the event reasonable attempts to contact me at ______________ (phone number) or ______________ (other parent) at ______________ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr.______________ (preferred Dr.), or Dr. ______________ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to ______________ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery are obtained before surgery is performed. Please provide facts concerning the child's medical history including: allergies, medications being taken, and any physical impairments to which a physician should be alerted:______________________________

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Signature of Parent:______________________________ Date: ______________

Address:______________________ City:______________ State:________ Zip Code:__________

PART II (REFUSAL OF CONSENT)

I DO NOT GIVE MY CONSENT for an emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the authorities to take no action or to ______________________________

Signature of Parent:______________________________ Date: ______________

Address:______________________ City:______________ State:________ Zip Code:__________

This form must be filled out completely and on file with the Parks and Recreation Department before the first day of the program.