Program
2340 F5
New 3/20/2020

Dublin City School District

Chaperone Emergency Medical Authorization Form

- To be completed by chaperone and returned to trip leader.
- To be used to authorize emergency medical treatment should a chaperone become ill or impaired while on trip.
- This information will be shared with emergency care providers if needed.

Chaperone name: _____ Date of birth: _____
Last First M.I.

Home address: _____
Street City, State, Zip Home phone Cell phone

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnosis, and treatment, including surgical intervention, if necessary, I authorize the individuals listed below to act on my behalf.

Adult to be notified in case of accident/emergency

Name: _____

Relationship: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Adult to be notified in case 1st adult listed cannot be reached

Name: _____

Relationship: _____

Home phone: _____

Cell phone: _____

Work phone: _____

Please list facts concerning your medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

Allergies: _____ _____ _____
(List what you are allergic to) (Type of reaction) (Usual treatment)

Medical condition: _____ Medications/treatment: _____

Physical impairments: _____

Please sign either the Consent for Treatment OR the Refusal to Consent for Treatment.

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

Doctor: _____ Ph: _____ Dentist: _____ Ph: _____

Medical Specialist: _____ Ph: _____ Local Hosp.: _____ Ph: _____

I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) my transfer to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____
Chaperone signature Date

Option II. REFUSAL TO CONSENT FOR TREATMENT
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:

Action: _____

_____ _____
Chaperone signature Date