ISLAMIC SOCIETY OF AKRON AND KENT

ISAK Sunday School

Emergency Medical Authorization

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who will become ill or injured while under school authority, when parents or guardians cannot be reached.
In case of your child's illness, we call the numbers you give us in the order listed. ***Four numbers*** help us in cases of emergency.

PARENTS OR GURDIAN

1. Mother Name_____ Mobile Number_____

2. Father Name_____ Mobile Number_____

Address_____
Number and Street

_____ _____ _____
City State Zip

OTHER RELATIVES OR RESPONSIBLE PARTIES

1. Name_____ Relationship_____ Mobile Number_____

2. Name_____ Relationship_____ Mobile Number_____

3.

PLEASE COMPLETE PART I OR II – NOT BOTH

PART I- TO GRANT CONSENT

In the event reasonable attempts to contact me or the numbers listed above have been unsuccessful, I hereby give consent for calling 911 and transfer of the child to the designated hospital or 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 such surgery, are obtained prior to the performance of such surgery.

Date_____ Parent or Guardian Signature_____

PART II-DO NOT GRANT CONSENT

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wi the school authorities to take no action or to:

_____

Date_____ Parent or Guardian Signature_____

Return to Office

Facts concerning the child's medical history including allergies and medications need to be taken during school time

Child Name_____ Date of Birth_____

Allergies: _____

Medications: _____

Child Name_____ Date of Birth_____

Allergies: _____

Medications: _____

Child Name_____ Date of Birth_____

Allergies: _____

Medications: _____

Child Name_____ Date of Birth_____

Allergies: _____

Medications: _____