

COSHOCOTON COUNTY BOARD OF DD
EMERGENCY MEDICAL AUTHORIZATION
2009-2010

Please fill out both sides completely

PART I

Name: _____ Telephone: _____
 Address: _____ E-Mail address _____
 Date of Birth: _____ Social Security Number: _____
 Medicare Number: _____ Medicaid Number: _____

 Insurance: _____ Carrier: _____

PART II

Check Box A or B Make sure to sign at BOTTOM

A I give my consent for:
 1. Transfer to the most accessible hospital, if needed and;
 2. Emergency Medical Treatment, as needed, by a licensed physician or dentist; and
 in the event emergency treatment is necessary, contact:

WE MUST HAVE 3 DIFFERENT CONTACTS OTHER THAN PARENT

Name/Address/Relationship to Student or Client	Home/Cell Phone	Work Phone	Employer
1. Parent/Guardian	H: _____		
	C: _____		
2. Other	H: _____		
	C: _____		
3. Other	H: _____		
	C: _____		
4. Other	H: _____		
	C: _____		

Parent/Guardian E-mail Address: _____

Preferred Physician: _____ Office Phone: _____

Address: _____ City: _____

Preferred Dentist: _____ Office Phone: _____

Address: _____ City: _____

Preferred Hospital: _____

Name of Care Provider: _____ Telephone: _____

B. I do not give consent for Emergency Medical Treatment. Staff may provide First Aid Treatment Only.
 In the event of illness or injury requiring Emergency Medical Treatment, I authorize staff to:
 _____ Take No Action; **or**

Signature: _____ Date: _____

(Parent, Guardian or Client)

This Authorization Valid For Up To 1 Year

EMERGENCY MEDICAL AUTHORIZATIONS ARE RENEWED ANNUALLY

OVER PLEASE

