

# St. Clairsville Department of Parks & Recreation

## Emergency Medical Authorization

**Purpose:** To enable parents and guardians of participants to authorize the provision of emergency treatment for the children or participants who become ill or injured while under Dept. of Parks & Recreation activities when the parent or guardian cannot be reached.

Participants Name: \_\_\_\_\_ Program Participating In: \_\_\_\_\_

### **Part I (To Grant Consent):**

In the event reasonable attempts to contact me \_\_\_\_\_,  
at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (cell phone) have been unsuccessful, I  
hereby give my consent for the administration of any treatment deemed necessary by the following doctors:

Preferred Physician \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist \_\_\_\_\_ Phone: \_\_\_\_\_

In the event the designated practitioner is not available, I consent to care by another licensed physician or dentist. If the transfer of \_\_\_\_\_ (participant's name) is necessary I grant consent of the transfer to \_\_\_\_\_ (preferred hospital) for any reasonable and necessary care. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the participant's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted in the space provided below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Do NOT complete Part II if you completed Part I*

### **Part II (Refusal to Consent)**

I do *NOT* give my consent for the emergency medical treatment of my child or myself. In the event of illness or injury requiring emergency treatment, I wish the St. Clairsville Department of Parks & Recreation authorities take no action to:

\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **HIPPA Consent:**

The St. Clairsville Department of Parks & Recreation acknowledge and abides by all rules of the HIPPA Act.

\_\_\_\_\_ Yes, I do consent to release emergency medical information on this form to the Recreation Department office staff, emergency personnel and coaches.

\_\_\_\_\_ No, I do consent to release any or all information pertaining to my child.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If participant is over 18) Revised on 8.25.14*