LaBrae Local Schools

Employee Emergency Medical Authorization

Employee Name _____ School Year _____

Address _____ Phone Number _____

City _____ State _____ Zip _____

Person to Be Notified in Case of an Emergency:

Contact Name _____ Relationship _____ Phone Number _____

Contact Name _____ Relationship _____ Phone Number _____

PURPOSE: To enable the employee to authorize the provision of emergency treatment for self when illness or employment injury occurs while fulfilling the requirements of employment of the LaBrae Board of Education.

Part I or II Must Be Completed

Part I: To Grant Consent

In the event reasonable attempts to contact the above listed persons have been unsuccessful, I hereby give my consent for: (1) The administration of any treatment deemed necessary by the following professionals:

Preferred Physician _____ Phone Number _____

Preferred Dentist _____ Phone Number _____

or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of self to _____ or any hospital reasonably accessible.
Preferred Hospital

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, or dentists, concurring in the necessity for surgery, are obtained prior to the performance of such surgery.

Facts concerning the employee's medical history, including medical history of allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Employee Signature _____ Date _____

Do Not Complete Part II If You Have Completed Part I

Part II: Refusal To Grant Consent

I do not give my consent for emergency medical treatment of myself. In the event of illness or injury requiring treatment, I wish the school authorities to take **NO ACTION** or to:

Employee Signature _____ Date _____