



P.O. Box 23129
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www.fieldstonefarmtrc.com

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

(Please complete all requested information)

Student's Name: _____ Phone: _____

Student is a (circle one): minor adult w/a legal guardian independent adult

Address: _____

Emergency Contacts:

In case of emergency, please contact: _____ Phone: _____

Other Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

Please note on the back of this form any medical considerations including allergies (bee stings, asthma, etc.), conditions requiring regular physician's care, and prescribed medications taken regularly.

AUTHORIZATION

The undersigned hereby grants to a staff member of Fieldstone Farm the authority to disclose and/or receive any information pertaining to the health care of the student, while participating in Fieldstone Farm programs, and to make health care decisions on their behalf in the event of a medical emergency which renders them incapable of obtaining or disclosing such information. The term "health care" and "health care decisions" as used in this form shall have the meanings set forth in Ohio Rev. Code sections 1337.11 through 1337.17.

___ I DO consent

___ I DO NOT consent*

Date: _____ Signature: _____

***In the event that consent is not authorized and in order for services to be rendered, an authorized person must remain on the premises and demonstrate proof of authorization, to be kept on file.**