



2023/2024 Emergency Medical Authorization Form

Website: www.deerparkdance.org Email: thedeerpark.danceprogram@gmail.com

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Phone: 513-560-3942

7034 Blue Ash Road, Silverton, Ohio 45236

Student Name _____

Address _____ Zip _____

Telephone_(_____)_____

Purpose – To enable parents, guardians or residential parent(s) to authorize the provision of emergency treatment for children who become ill or injured under Deer Park Dance Program authority, when parents or guardians or residential parent(s) cannot be reached.

Parent/Legal Guardian Name _____

First

Last

Daytime Phone_(_____)_____

Parent/Legal Guardian Name _____

First

Last

Daytime Phone_(_____)_____

Other's Name _____

First

Last

Daytime Phone_(_____)_____

Name of Relative or Child Care Provider _____

Address _____

Relationship _____ Daytime Phone_(_____)_____

-continued on second page-

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone_(_____)_____

Dentist _____ Phone_(_____)_____

Medical Specialist _____ Phone_(_____)_____

Local Hospital _____ Emergency Room_(_____)_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

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

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

Date _____

Signature of Parent/Legal Guardian _____

Address _____ Zip _____

PART II: REFUSAL TO 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 wish Deer Park Dance Program authorities to take the following action:

Date _____

Signature of Parent/Legal Guardian _____

Address _____ Zip _____

Note: If refusing consent to emergency medical treatment the parent/guardian must remain in the lobby during all classes and at the high school during all rehearsals and recitals with their dancer. If the parent/guardian is not present the dancer will not be able to participate and the parent/guardian will be contacted to pick their child up. If a medical emergency occurs during the time the parent/guardian is not present the instructor will call 911 for medical assistance at their discretion.