Overbeke Driving School LLC

5815 Landerbrook Drive

P.O. Box 24486

Mayfield Heights, Ohio 44124

Emergency Medical Authorization Form

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Parent/Guardian Emergency Contacts

In an emergency, the school will FIRST attempt to contact the Parent/Guardians:

Parent/Guardian #1

Name_____________________________________

Cell____

Home_____________________________________

Work______________________________________

Parent/Guardian #2

Name_____________________________________

Cell____

Home_____________________________________

Work______________________________________

If the school cannot reach the above, please list the other person(s) below who may be notified and to whom your child may be released:

Other Emergency Contacts (when Parent/Guardians cannot be reached)

Emergency Contact #1:

Name_____________________________________

Number___________________________________

Relation to Child___________________________

Emergency Contact #2:

Name____________________________________

Number__________________________________

Relation to Child__________________________

Emergency Contact #3:

Name___________________________________

Number_________________________________

Relation to Child_________________________

Consent for Treatment

Please indicate whether you approve or refuse to grant consent for treatment for your child.

________ Approve ___________ Refuse

In the event that reasonable attempts to contact PARENT/GUARDIANS were made, I/we do

hereby consent for:

• (1) The administration of any treatment deemed necessary by:

Dr. (preferred physician) at the following phone #:

Dr. (preferred dentist) at the following phone #:

Dr. (medical specialist) at the following phone #:

Or, in the event the preferred physician or dentist is not available then consent is given for treatment by any licensed physician or dentist and:

• (2) The transfer of the child to (preferred hospital) at the following phone # or any hospital reasonably accessible:

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur on the necessity for such surgery to be obtained prior to the performance of such surgery. The following are facts concerning the child's medical history including allergies, medications being taken, medical conditions, and any physical impairments to which the physicians or dentist should be alerted:

Existing Medical Conditions:

Medications:

Allergies:

Required Form Signatures

I/We agree that this form is complete and accurate, and the signature is that of the legal guardian of the student above.

Parent/Guardian Signature:_______________________________________

Printed Name:____

Date:____