

**EMERGENCY MEDICAL AUTHORIZATION FORM
O.R.C. 3313.712**

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who will become ill or injured while under Central Ohio Chapter, Ohio Young Birders Club or Columbus Audubon authority, when parents or guardians cannot be reached.

Student's Full Name (please print) _____

Address _____

Telephone _____ Grade _____

Birth Date: mm/dd/yy _____

Mother's Full Name _____ Phone _____ - _____ - _____

Father's Full Name _____ Phone _____ - _____ - _____

Guardian's Full Name _____ Phone _____ - _____ - _____

Part I - To Grant Consent:

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

Name of Physician _____ Phone _____ - _____ - _____

Name of Dentist _____ Phone _____ - _____ - _____

Name of Preferred Hospital _____ Phone _____ - _____ - _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give the Central Ohio Chapter of the Ohio Young Birders Club and Columbus Audubon representatives my consent for (1) the administration of any treatment deemed necessary by the above named doctor, 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 a hospital reasonably accessible. This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring on the necessity of such surgery, are obtained prior to the performance of such surgery.

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

Signature of Parent or Guardian _____ Date _____

Part II - Refusal to Consent

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish Central Ohio Chapter of the Ohio Young Birders Club and Columbus Audubon authorities to take the following action:

Signature of Parent or Guardian _____ Date _____

Please return to: OYBC-Central Ohio Chapter, c/o Gerry Brevoort, OYBC Coordinator, 171 Erie Road, Columbus, OH 43214