CASE AMBASSADORS CONSENT FORM

Authorization for Emergency Medical Treatment and Transportation to Obtain Emergency Medical Treatment

Student/Visitor’s Name (Required) ________________________________________________
Case Ambassador’s Name (Required) ________________________________________________

Student/Visitor Information (At Least One Name and One Phone Number Required)

Mother’s Name ________________________________________________________________
Mother’s Phone Number(s): Day: (______) ____________________________
                          Evening: (______)

Father’s Name ________________________________________________________________
Father’s Phone Number(s): Day: (______) ____________________________
                          Evening: (______)

Guardian’s Name ______________________________________________________________
Guardian’s Phone Number(s): Day: (______) ____________________________
                          Evening: (______)

If providing telephone numbers for more than one individual, please indicate whom Case should contact first.

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment and transportation for students/visitors who become ill or injured while at Case Western Reserve University when parents cannot be reached.

In the event reasonable attempts to contact me have been unsuccessful or an emergency exists making it practical or dangerous to delay treatment, in order to obtain such consent, I hereby give my consent (1) for the administration for any treatment deemed necessary by a licensed physician or dentist; and (2) for the administration for the transfer of my son/daughter to any hospital reasonably accessible.

This 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 or mental impairment to which a physician should be alerted may be indicated here:

________________________________________________________________________

________________________________________________________________________

Signature of Parent or Guardian (Required) ________________________________________

***If Parent or Guardian is Not Present, Student/Visitor May Sign***

Signature of Ambassador (Required) _____________________________________________

Date __________________________