REACH OUR YOUTH (ROY)
HURON COUNTY COMMON PLEAS COURT
2 E. MAIN STREET, ROOM 102
NORWALK, OHIO 44857-1534
Phone: (419) 663-2525 Fax: (419) 663-0944
E-Mail: roy@hcjpc.com **Web:** http://reachouryouth.weebly.com

MEDICAL CONSENT

Child's Name

Address, City and State

Phone & E-mail Address

I, the undersigned parent/guardian of the above named youth; do hereby grant authorization and consent to Reach Our Youth (ROY) and/or its properly assigned private agents to obtain for my child any emergency medical, dental or hospital treatment deemed necessary while my child is participating in the Reach Our Youth (ROY) program. I understand that all reasonable attempts will be made to contact us before any treatment is administered. Upon failure to reach me, I give consent to Reach Our Youth (ROY) or its agent to contact our family physician or dentist to obtain permission to treat my child. In the event that neither I nor my physician or dentist can be reached, we hereby authorize Reach Our Youth (ROY) or its agents to transfer my child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of my physician, or in the event that my physician cannot be reached, the opinion of a qualified physician practicing emergency room procedures is such that surgery is required to save the life or limb of my child.

I, the undersigned parent, guardian or legal custodian of the above named child further state that we are signing this consent voluntarily and of my own free will and accord.

Date

Parent or Guardian

Witness

REFUSAL TO CONSENT FOR MEDICAL TREATMENT

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 Reach Our Youth (ROY) to take no action.

Parent or Guardian

Date

over

REACH OUR YOUTH (ROY) EMERGENCY MEDICAL AUTHORIZATION

Child

Phone

Address

A. CONSENT FOR MEDICAL TREATMENT

Physician's Name

Phone

Dentist's Name

Phone

Preferred Hospital

Phone

Whom to notify in case of an emergency:

Name

Daytime Phone

Address

Evening Phone

Insurance:

Company Name/Agent

Policy #

B. MEDICAL HISTORY

Has child had problems with:

Ear infections ☐
Heart problems ☐
Convulsions/seizures ☐
Diabetes ☐
Asthma ☐
Epilepsy ☐
Poison Ivy ☐
Rheumatic fever ☐
Allergies ☐
If, yes, list: _____

Does child have any reactions to any medications? _____
Does child have any reaction to bee stings? _____
Does child take any medications? _____

Parent or Guardian

Date

Address

Revised: 05/2017