

**Women Writing for (a) Change Foundation  
6906 Plainfield Road  
Cincinnati, OH 45236**

**Emergency Medical Authorization**

This form enables us to obtain emergency medical treatment for your daughter in the event she becomes ill or injured while in our care when you cannot be reached. You may also refuse to grant this authorization by filling out section C. Please complete **Section A and EITHER Section B or C** and mail the form to the address above, or send with your daughter on the first day of class. **This form must be completed and returned prior to leaving your daughter at Young Women Writing for (a) Change.**

**Section A.**

Daughter: \_\_\_\_\_ Parent \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Daughter's Date of Birth \_\_\_\_\_

**Contact Information:**

\_\_\_\_\_  
Parent Home Phone Work Phone

\_\_\_\_\_  
Parent Home Phone Work Phone

\_\_\_\_\_  
Step-Parent Home Phone Work Phone

\_\_\_\_\_  
Nearest Friend or Relative Home Phone Work Phone

IMPORTANT MEDICAL INFORMATION concerning my daughter's medical history including allergies, medication being taken, and any physical impairments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I agree that neither Women Writing for (a) Change, nor any persons involved in its programs shall be held responsible for injury, illness, or damages to the person or property of my daughter while attending classes.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**OVER**

**Section B. To Grant Consent:**

In reasonable attempts to contact the persons above are unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the preferred physician or dentist, or, in the event the designated practitioner is not available, another licensed physician or dentist; (2) the transfer of my daughter to the preferred hospital or any hospital reasonably accessible and (3) I further give consent to treatment of my daughter during transportation by available medical technician ambulance to a treatment facility.

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Preferred Physician	Address	Phone
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Preferred Dentist	Address	Phone
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Preferred Hospital	Address	Phone
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This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring as to the necessity for such surgery, are obtained before surgery is performed

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Signature of Parent/Guardian	Date
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**Section C. Refusal to Grant Consent (Do Not Complete If You Granted Consent)**

I do not give my consent to emergency medical treatment of my daughter. In the event of illness or injury requiring emergency treatment, I wish Women Writing for (a) Change to take NO action, or to: \_\_\_\_\_

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Signature of Parent/Guardian	Date
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