EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Student Name____ Grade/Rm:________________
(Please Print) Last First

Date of Birth_______________________________ Home Phone_______________________________

Address___________________________________ City________________________Zip___________

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name___________________________________ Daytime Phone_____________________________

Father's Name____________________________________ Daytime Phone_____________________________

Emergency Contacts: Please list 3 close contacts that would be able to assume care of your child if you are unable to be reached.

1.____ Phone Number______________________________

2. ____ Phone Number______________________________

3.____ Phone Number______________________________

It is extremely important that you provide ANY pertinent medical history or information about existing conditions that my affect your child at school.

Medical Information____

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Medications____

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Allergies____

PART 1 or PART II MUST BE COMPLETED

PART 1: To Grant Consent

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

Doctor___________________________ Phone________________

Dentist____________________________Phone_______________

Medical Specialist______________________________________

Phone__________________________________

Local Hospital/ER______________________________________

Phone__________________________________

In the event reasonable attempt to contact me have unsuccessful, I hereby five my consent for: 1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of the child 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

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Parent/Guardian Signature **Date**

PART 2: Refusal to Consent

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 the school authorities to take the following action:

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Parent/Guardian Signature **Date**