EMERGENCY MEDICAL AUTHORIZATION FORM
O.R.C. 3313.712

ID_____

Student Name_____ Grade_____ Teacher_____
LAST FIRST

Address_____ DOB _____Bus_____

_____ Email_____

Home Telephone _____ Custody information/Lives with_____

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. Allow others to pick up child from school when needed.

Call first

Mother's Name: _____ Daytime Phone:_____Cell ph._____□

Address:_____ Work Phone:_____

Father's Name: _____ Daytime Phone:_____Cell ph._____□

Address:_____ Work Phone:_____

Other's Name: _____ Relationship:_____ Phone #:_____ □

Other's Name: _____ Relationship:_____ Phone #: _____ □

Other's Name: _____ Relationship:_____ Phone #:._____□

Siblings attending in district (name & building)_____

PART I OR II MUST BE COMPLETED

PART I – 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: _____ Emergency Room Phone: _____

Does your child currently wear or has ever worn: _____ glasses _____contacts _____hearing aids

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by 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 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, CURRENT OR PAST HEALTH ISSUES:_____**

_____

****** CURRENT MEDICATIONS TAKEN:**_____

_____

_____ _____

Date **Signature of Parent/Guardian**

PART II – TO REFUSE 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: _____

_____

_____ _____

Date **Signature of Parent/Guardian**

❑ **Check this box if you DO NOT want us to share pertinent medical information with staff involved with your child.**