

Conneaut Area City Schools

BOARD OFFICES, 230 Gateway Avenue, Conneaut OH 44030 – 440-593-7200

EMERGENCY MEDICAL AUTHORIZATION 2020/2021 School Year

<p align="center">IMPORTANT PLEASE READ</p> <p>This form (front & back) must be completed and returned to school the next school day.</p> <p>Failure to do so may result in your child being excluded from attending school.</p> <p>You must notify the school immediately when your address, phone or other contact information has been changed.</p>	<table style="width:100%; border-collapse: collapse;"> <tr><td style="border-bottom: 1px solid black; text-align: center;">Student Name</td></tr> <tr><td style="border-bottom: 1px solid black; text-align: center;">Student's Address</td></tr> <tr><td style="border-bottom: 1px solid black; text-align: center;">Student's Home Phone Number</td></tr> <tr><td style="border-bottom: 1px solid black; text-align: center;">School Building</td></tr> <tr> <td style="border-bottom: 1px solid black; text-align: center;">Homeroom</td> <td style="border-bottom: 1px solid black; text-align: center;">Teacher</td> </tr> </table>	Student Name	Student's Address	Student's Home Phone Number	School Building	Homeroom	Teacher
Student Name							
Student's Address							
Student's Home Phone Number							
School Building							
Homeroom	Teacher						

Grade	Locker No.	Bus No.	Birth Date
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Parent/Guardian Information

Parent Status:	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Separated	<input type="checkbox"/> Never Married	<input type="checkbox"/> Deceased:
	<input type="checkbox"/> Both	<input type="checkbox"/> Mother	<input type="checkbox"/> Father			

Student lives with: Please check ALL that apply	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____
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Custody of Student: Please check ALL that apply	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Other: _____
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Parent/Guardian Contact 1	Parent/Guardian Contact 2
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Name and Relationship		
Address if different than student		
Primary Contact Phone		
Mobile Phone		
Email Address		
Employer		
Work Phone		

If your child should become ill or hurt while at school and we are unable to reach you, we must have the name or names of SOMEONE ELSE LOCAL TO CALL FOR ASSISTANCE.

Please list below: DESIGNATED PERSON(S)

Name _____	Relationship _____
Address _____	Phone: _____ Cell _____
Name _____	Relationship _____
Address _____	Phone: _____ Cell _____

BROTHERS/SISTERS IN THE DISTRICT

Name & Grade	Name & Grade	Name & Grade

The purpose of this Emergency Medical Authorization is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill and/or injured while under school authority, when parents/guardians cannot be reached.

OVER ⇨

EMERGENCY MEDICAL AUTHORIZATION

Military Status (If applicable): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Guard <input type="checkbox"/> Reserve <input type="checkbox"/> NA	Military Branch: <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard
Military Status (If applicable): <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Guard <input type="checkbox"/> Reserve <input type="checkbox"/> NA	Military Branch: <input type="checkbox"/> Army <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Navy <input type="checkbox"/> Coast Guard

PART I To Grant Consent

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

Physician _____ Phone _____
 Address _____

Dentist _____ Phone _____
 Address _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me or - **MY DESIGNATED PERSON/S** have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors or by another licensed physician or dentist in the event the designated preferred practitioner is not available and (2) the transfer of my 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 performance of such surgery.

List and explain facts concerning the child's medical history including: allergies, current medications, and any illness or physical impairment to which a physician should be alerted.

_____ Date _____ Signature and relationship to student
 Address _____

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PART II 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:

AND In a life-threatening emergency, Ashtabula County EMIS protocol dictates that the patient be taken to the nearest facility.

_____ Date _____ Signature and relationship to student
 Address _____