**Western Local Schools**

**Emergency Medical Authorization Form (EMA)**

**Primary/Elementary Phone: 740-493-2881**

**Junior High/High School Phone: 740-493-2514**

|  |  |
| --- | --- |
| **Today’s Date:** Click here to enter today’s date. | **School Year:** Choose current school year. |
| **Enrollment Type:** Choose enrollment type. | **Social Security Number:** Click here to enter SSN. |
| **Student Last Name:** Click here to enter last name. | **Gender:** Choose gender. |
| **Student First Name:** Click here to enter first name. | **MI:** Click here to MI |

|  |  |
| --- | --- |
| **Street Address** | Click here to enter street. |
| **City** | Click here to enter city. |
| **State** | Click here to enter state. |
| **Zip Code** | Click here to enter zip. |

**Last School District Attended: (if not Western):** Click here to enter school (other than Western.

**Bus Number (if current student):** Click here to enter bus number.

***Purpose of EMA: To enable parents and guardians to authorize the provision of emergency treatment and/or pickup for children who become ill or injured while under school authority when parents or guardians cannot be reached.***

**Please list all emergency and pickup list numbers. This contact information is used by the school nurse.**

**Mothers’ Name:** Click here to enter name.

|  |  |  |
| --- | --- | --- |
| **Home:** Click here to enter number. | **Cell:** Click here to enter number. | **Work:** Click here to enter number. |

**Fathers’ Name**Click here to enter name.

|  |  |  |
| --- | --- | --- |
| **Home:** Click here to enter number. | **Cell:** Click here to enter number. | **Work:** Click here to enter number. |

**Guardian Name:** Click here to enter name. **Relationship:**Click here to enter relationship.

|  |  |  |
| --- | --- | --- |
| **Home:** Click here to enter number. | **Cell:** Click here to enter number. | **Work:** Click here to enter number. |

**Please list all others who have the authority to pick up your child or authorize emergency treatment**

**Name Phone**

|  |  |
| --- | --- |
| Click here to enter name. | Click here to enter number. |
| Click here to enter name | Click here to enter number. |
| Click here to enter name | Click here to enter number. |
| Click here to enter name. | Click here to enter number. |
| Click here to enter name. | Click here to enter number. |

**List School Aged Brothers and Sisters or other children living in the home:**

**Name Age School Attended (if not Western)**

|  |  |  |
| --- | --- | --- |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |
| Click here to enter name. | Click here to enter age. | Click here to enter school. |

**Grant Consent Part 1:**

**I hereby give consent for the following medical care providers to be called:**

|  |  |  |
| --- | --- | --- |
| **Physician** | Click here to enter name. | Click here to enter phone. |
| **Dentist** | Click here to enter name. | Click here to enter phone. |
| **Medical Specialist** | Click here to enter name. | Click here to enter phone. |

**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 the above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.**

**I give my consent for the release of medical information to school personnel.**

**List facts concerning the child’s medical information:**

**Diagnosis:**

Click here to enter medical diagnosis.

**Medications currently being taken:**Please list medications.

**Allergies:**Please specify any allergies.

**Physical Impairments** Click here to enter information.

|  |  |
| --- | --- |
| **Date** Select Date. | **Signature of Parent/Guardian:** Click here to sign . |

**By typing my name or electronically signing I am certifying my consent**