WESTERN LOCAL SCHOOLS
Emergency Medical Authorization Form (EMA)
Primary/Elementary Phone: 740-493-2881 Fax: 740-493-1059
JR/High School Phone: 740-493-2514 Fax: 740-493-8513

Today's Date _____ School Year_____ Grade _____

Status: Please Check One:

New__ Re-enrolled ____Current____

SS#_____

AM Bus#_____PM Bus#_____

Students' Name _____

Date of Birth_____ Male ____Female_____

Address_____

_____ State_____ Zip Code_____

Last School District Attended_____ State_____

EMA-Purpose: To enable parents & 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 & PICKUP LIST NUMBERS. THIS CONTACT INFORMATION IS USED BY THE SCHOOL NURSE.

Mother's Name _____ Phone#_____ Cell#_____ Work#_____
Father's Name _____ Phone#_____ Cell#_____ Work#_____
Name_____#_____
Name_____#_____
Name_____#_____
Name_____#_____

List Brothers & Sisters or other children living in the home: Please put both First & Last Names.

Name _____ Age____ Name_____ Age_____
Name _____ Age____ Name_____ Age_____
Name _____ Age____ Name _____ Age_____

Grant Consent Part 1:
I hereby give consent for the following medical care providers to be called:
Physician _____ Phone# _____
Dentist _____ Phone # _____
Medical Specialist _____ 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 opinions 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:
_____

Medications Currently Taking:
_____

Allergies:
_____

Physical Impairments:
_____

Date: _____ Signature of Parent/Guardian_____