EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____ School _____

Street Address _____ **Home** Phone _____

City _____ Zip _____ Grade_____

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.

Residential Parent or Guardian

Cell Phone_____

Mother's Name _____ **Work** Phone_____ Email*_____

Cell Phone_____

Father's Name _____ **Work** Phone_____ Email*_____

"Please provide email addresses only if you agree to be contacted by district staff via email including mass district announcements. (You will have the capability to unsubscribe from district announcements if you choose.) Providing the school district with your personal e-mail address will result in your e-mail address being added to our student information system. As a result, your e-mail address will become subject to public records request regulations."

Other's Name _____ **Cell** Phone _____ **Work** Phone_____

Relative or Childcare Provider

Name _____ Daytime/Work/Cell Phone _____

Address _____ Relationship _____

SECTION 3313.712 of the Ohio Revised Code requires this form to be filled out and on file for each student in attendance in each building of the school district. Thank you for your cooperation. PART 1 OR 2 MUST BE COMPLETED.

PART 1: TO GRANT CONSENT

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

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist_____ Phone _____

Local Hospital _____ 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 above-named doctors, 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, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Signature of Parent/Guardian _____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 actions:

_____

_____

Signature of Parent/Guardian _____Date_____