§ JHC-A

EMERGENCY MEDICAL AUTHORIZATION FORM

Bellaire Local School District

Birthday ____________________

School ________________________ **Student Name** ____________________________________

Grade ______________ **Address** _______________________________ **City** _________________

BUS # _________ **Telephone** _________________

RESIDENTIAL PARENT OR GUARDIAN

Mother ______________________________ **Daytime Phone/e-mail** ___________________

Father _______________________________ **Daytime Phone/e-mail** ___________________

Other Name _________________________ **Daytime Phone/e-mail** ___________________

List Names with permission to pick-up child

1.____Phone:___________________________

2. _______________________________________ Phone:__________________________

3. _______________________________________ Phone:__________________________

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatments for children who become ill or injured while under school authority, when parents or guardians cannot be reached. (Leg. Rev. O.R.C.)

PART I - CONSENT

In the event reasonable attempts to contact me at the above # or other parent and/or relative have been unsuccessful, I HEREBY GIVE MY consent for

1) the administration of any treatment deemed necessary by Doctor or Dentist listed below, or, in the event the designated preferred doctor/dentist is not available by another licensed physician or dentist; and
2) the transfer of the child to hospital listed below or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Doctor _______________________________________ Phone ___________________________

Dentist _______________________________________ Phone ___________________________

Medical Specialist ____________________________Phone ___________________________

Local Hospital ________________________________Phone ___________________________

LISTED ARE THE FACTS CONCERNING MY CHILD'S MEDICAL HISTORY WHICH INCLUDE ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY OTHER PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:

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Date __________ Signature _________________________Address ___________________________

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:

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Date _______________Signature _____________________ Address ___________________________