EMERGENCY MEDICAL AUTHORIZATION
(3313.712 Ohio Revised Code)
Fayetteville-Perry Local Schools

____ PLEASE CHECK IF ADDRESS CHANGED FROM LAST YEAR

Student's Name ______________________________ ***D.O.B.*** ____________ ***Phone #*** __________________

Street Address ____________________________ ***P.O. Box*** _____ ***City*** ________________ ***Zip*** ___________

Soc. Sec. # ______________________ ***Grade*** ____ ***Teacher*** __________________ ***Bus #*** ________

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.

Mother's Name ____________________________________ ***Daytime Phone*** ________________________________
e-mail address _________________________________
Father's Name ___________________________________ ***Daytime Phone*** ________________________________
e-mail address _________________________________

Child lives with: (please check) mother ____ ***step-mother*** _____ ***father*** _____ ***step-father*** ____
grandmother _____ ***grandfather*** ______ ***other*** ______ ***, (relationship)*** ______________

If separated or divorced - who has custody _____________ ***Custody papers MUST be on file in the office.***

Other emergency numbers to call: Please identify, neighbors, relatives, etc.

___________________________ ***phone #*** ____________ , _________________________ ***phone #*** ______________
(name) ***(name)***
___________________________ ***phone #*** ____________ , _________________________ ***phone #*** _______________
(name) ***(name)***

LIST ONLY THOSE WHO HAVE PERMISSION TO PICK UP YOUR CHILD

**************************** PART I *OR* PART II MUST BE COMPLETED ****************************

PART I (TO GRANT CONSENT)

Physician ____________________ Phone # ___________, Dentist ___________________ Phone # ______________

Local Hospital _________________________________ Medical Specialist _________________________________

Facts concerning the child's medical history including allergies, current medications, and any physical impairments to which a physician should be alerted: ____
____
____

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.

Date _________________________ **Signature of Parent/Guardian** _______________________________________

********************DO NOT COMPLETE PART II IF YOU COMPLETED PART I ***********************

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:____
____

Date _________________________ **Signature of Parent/Guardian** ____