EMERGENCY MEDICAL AUTHORIZATION FORM
O.R.C. 3313.712

School_____ Student Name_____

DOB _____ Address _____

Grade _____ _____

Telephone _____

☐ **Check this box if you DO NO want us to share pertinent medical information with staff involved with your child.**

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

Mother's Name: _____ Daytime Phone:_____Cell ph._____

Father's Name: _____ Daytime Phone:_____Cell ph._____

Other's Name: _____ Daytime Phone:_____Cell ph._____

Name of Relative or Childcare Provider:

_____ Relationship: _____

Address; _____ Phone: _____Cell ph._____

PART I (this page) OR II (second page) MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room 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 doctor, or m 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 IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:_____

_____

_____

Does your child currently wear or has ever worn: ☐ glasses ☐ contacts ☐ hearing aids

_____ _____

(date) (Signature of Parent/Guardian)

Address: _____

PARTII - TO REFUSE 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)

Address: _____