

**EMERGENCY MEDICAL AUTHORIZATION FORM  
O.R.C. 3313.712**

ID \_\_\_\_\_

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Address \_\_\_\_\_ LAST FIRST \_\_\_\_\_ DOB \_\_\_\_\_ Bus \_\_\_\_\_

Email \_\_\_\_\_

Home Telephone \_\_\_\_\_ Custody information/Lives with \_\_\_\_\_

**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. Allow others to pick up child from school when needed.

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell ph. \_\_\_\_\_  Call first

Address: \_\_\_\_\_ Work: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell ph. \_\_\_\_\_

Address: \_\_\_\_\_ Work: \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell ph. \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell ph. \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell ph. \_\_\_\_\_

Siblings attending in district (name & building) \_\_\_\_\_

**PART I OR II 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: \_\_\_\_\_

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

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 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 IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:** \_\_\_\_\_

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(Signature of Parent/Guardian)

Address: \_\_\_\_\_

**PART II – 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: \_\_\_\_\_

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\_\_\_\_\_  
(date)

\_\_\_\_\_  
**(Signature of Parent/Guardian)**

Address: \_\_\_\_\_

**Check this box if you DO NOT want us to share pertinent medical information with staff involved with your child.**