EMERGENCY MEDICAL AUTHORIZATION FORM (Revised 5/2019)
O.R.C. 3313.712

ID____________________

Student Name____ Grade___________ Teacher_________________
LAST FIRST

Address____ 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.

Call first

Mother's Name: __________________________________ Daytime Phone:_________________________Cell ph.______________________ □

Address:____ Work Phone:____

Father's Name: __________________________________ Daytime Phone:_________________________Cell ph.______________________ □

Address:____ Work Phone:____

Other's Name: _________________________________ Relationship:____________________________ Phone #:______________________ □

Other's Name: _________________________________ Relationship:____________________________ Phone #: ______________________ □

Other's Name: _________________________________ Relationship:___________________________ Phone #:.______________________ □

Siblings attending in district (name & building)____

PART I OR II <u>MUST</u> BE COMPLETED

<u>PART I – TO GRANT CONSENT</u>

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, CURRENT OR PAST HEALTH ISSUES:**____

____

****** CURRENT MEDICATIONS TAKEN:**____

____

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

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: ____

____

____________________ ____

Date **Signature of Parent/Guardian**

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