

Circle One
Bus No. _____ AM/PM
Bus No. _____ AM/PM
Other _____

EMERGENCY MEDICAL AUTHORIZATION FORM

O.R.C. 3313.712

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.

Student's Name _____ Birthdate _____ Grade _____

Home Address _____ PO Box # _____

City, State/Zip _____ Teacher _____

Student resides with (circle all that apply) mother father step-parent guardian other _____
If custody is involved with whom is the student living? _____

List the names (first and last names) of those who have authority to make decisions in an emergency situation involving the student.

Indicate on the line to the left of the name the order in which you would like contacts to be made (1st, 2nd, etc)

____ Mother: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment _____

____ Father: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment _____

____ Step-parent: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment _____

____ Guardian: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment _____

____ Other Contact: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____

Place of Employment _____

Siblings: Name: _____ Grade: _____ School: _____

Name: _____ Grade: _____ School: _____

Permission for picture publication (Newspaper, school articles, etc.): Yes _____ No _____

Permission for Tylenol for headache (Grades 9 through 12 only): Yes _____ No _____ Must fill out district medication sheet.

COMPLETE **ONLY ONE** OF THE FOLLOWING: 1. Consent for Treatment **or** 2. Refusal to Consent

1. CONSENT FOR TREATMENT:

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

Preferred Physician: _____

Office Phone: _____

Preferred Dentist: _____

Office Phone: _____

Medical Specialist: _____

Office Phone: _____

Preferred Hospital: _____

2. 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:

Parent/Guardian Signature _____

Date: _____

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 the preferred doctor indicated, 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 surgery.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medication being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

Parent/Guardian Signature: _____ Date: _____
(consent for treatment)

School staff may be notified of above medical conditions unless otherwise notified.