EMERGENCY MEDICAL AUTHORIZATION

School: _____   Student Name: _____

Address: _____

Telephone: _____

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: _____
Father's Name: _____   Daytime Phone: _____
Other's Name: _____   Daytime Phone: _____
Name of Relative or Childcare Provider: _____   Relationship to Child: _____
Address: _____   Phone: _____

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: _____

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 (2) 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 – 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: _____

Address: _____

R.C. 3313.712

Supplemental Information (optional):

Student's Birthdate: _____   Grade:_____

Teacher/Homeroom: _____

Date of Last Tetanus: _____

Student resides with (circle all that apply)   Mother   Father   Stepparent   Guardian Other: _____

_____

Additional Contact Information for those who have authority to make decisions in an emergency situation involving this student.

Mother: _____ Home#: _____ Work#: _____ Mobile#: _____

Father: _____ Home#: _____ Work#: _____ Mobile#: _____

Stepparent: _____ Home#: _____ Work#: _____ Mobile#: _____

Guardian: _____ Home#: _____ Work#: _____ Mobile#: _____

Alternate: _____ Home#: _____ Work#: _____ Mobile#: _____
(relative child care provider)