Emergency Medical
O.R.C. 3313.712

The Purpose of this form is 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 Name	Grade	Birth Date	Parent's Name
_____	_____		_____
Address	Home Phone		Bus Number

Emergency Contacts

#1 Name: _____ Relationship: _____ Home Phone: _____

Cell Number: _____ Work Phone: _____

#2 Name: _____ Relationship: _____ Home Phone: _____

Cell Number: _____ Work Phone: _____

#3 Name: _____ Relationship: _____ Home Phone: _____

Cell Number: _____ Work Phone: _____

#4 Name: _____ Relationship: _____ Home Phone: _____

Cell Number: _____ Work Phone: _____

The above contacts will be reached in order as listed. Listed emergency contacts are permitted to pick up the student in the event of illness: the parent has been attempted to be reached. It is the parent's responsibility to notify the school with any changes.

Authorization for Medical Treatment

I hereby give consent for the following medical care providers to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

Name of Medical Insurance: _____ Policy Number: _____

Medical History: _____

Medications and Dosages: _____

Allergies and Reaction: _____

Does you child need an EpiPen here at school? _____ Yes _____ No

List any accommodations or restrictions that need to be made for you child here at school:

Does you child need an inhaler while in school? _____ Yes _____ No

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the closest emergent facility. This authorization does not cover major surgery unless the medical opinions to two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained to the performance of such surgery.

Signature or Parent/Guardian: _____ Date: _____

PLEASE COMPLETE REVERSE SIDE ONLY IF YOU DO NOT GRANT CONSENT

Emergency Medical Authorization Form

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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 no action or to:

_____

_____

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____