

## EMERGENCY MEDICAL AUTHORIZATION & INFORMATION

Student's Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Birth Date: \_\_/\_\_/\_\_ Grade: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Other Phone: (\_\_\_\_) \_\_\_\_\_

Date of Last Tetanus Shot: \_\_\_\_\_ (Required) Date of 2<sup>nd</sup> MMR \_\_\_\_\_ (Required for incoming 7<sup>th</sup> graders)

My child is allergic to: \_\_\_ Hay/straw \_\_\_ Dairy Products \_\_\_ Bee Stings \_\_\_ Nuts \_\_\_ Medications (please list): \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_ If any of these are considered life-threatening allergies, please describe: \_\_\_\_\_

My child has/had: \_\_\_ Seizures \_\_\_ Heart Disease \_\_\_ Diabetes \_\_\_ Asthma \_\_\_ Homesickness

- Other medical conditions \_\_\_\_\_
- Other physical, emotional, mental, or behavioral concerns or limitations \_\_\_\_\_

If your child requires medication, please read the Medication Policy in the Student/Parent Handbook. If you permit your child to carry and administer his or her own medication while in the school's care, please be advised that you must obtain a permission slip from the office and that you and your child shall be totally responsible for the safekeeping of the medication and the administration of the correct dosage.

Medications being taken: \_\_\_\_\_

Please indicate your consent for this student to be administered the following medications in accordance with directions, as follows:

___ Generic Tylenol for pain	___ Do nothing before you call me
___ Maalox/Tums for upset stomach	___ Do nothing before you call me
___ Generic Sudafed for congestion	___ Do nothing before you call me
___ Immodium AD for diarrhea	___ Do nothing before you call me
___ Benadryl for allergy symptoms/congestion	___ Do nothing before you call me

**TO PARENTS AND GUARDIANS:** This is to authorize, or to decline 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 for the purpose of giving consent for such treatment. Such authority is necessary to overcome legal obstacles to the provision of treatment when all reasonable attempts to reach parents or guardians have failed. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. The authority granted by this form meets the specifications outlined by Section 3313.712 of the Ohio Revised Code.

### PART I - TO GRANT CONSENT

Doctor: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name of person who will assume financial responsibility for medical treatment: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

### PART II - REFUSAL TO GIVE CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to: \_\_\_\_\_

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_