STUDENT NAME_____
(*Please print*) Last First (ID #)

Centerville City Schools
EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth_____ Home Phone_____

School_____ Address_____

School Year_____ Grade_____ City _____Zip_____

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name_____ Daytime Phone_____ Cell_____

Father's Name_____ Daytime Phone_____ Cell_____

Emergency Contacts:
1. _____ Daytime Phone_____ Cell_____
2. _____ Daytime Phone_____ Cell_____
3. _____ Daytime Phone_____ Cell_____

Please identify any health concerns that school personnel should be aware of:

Allergies: No _____ Yes____Specify_____

Epi-pen: No _____ Yes____***If yes, Epi-pen Authorization Form must be completed.***

Asthma: No _____ Yes____***If yes, Inhaler Authorization Form must be completed.***

Seizures: No _____ Yes____Emergency seizure medications?_____
Name of medications

Diabetes No _____ Yes Emergency diabetic medications?_____
Name of medications

Does your student take any medication regularly? ___ No ___ Yes Specify_____
Name of medication, amount taken, how often

Will your student take medication at school? ___ No ___ Yes ***If yes, Permission to Dispense Medication Form must be completed.***

Are there any other medical conditions that school personnel should be aware of?_____

_____

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 doctors, or, in the event the designated 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.

_____
Signature of Parent/Guardian Date

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:

_____

_____

_____

_____

_____

_____
Signature of Parent/Guardian Date

Form Revised 7/087