



**EMERGENCY MEDICAL AUTHORIZATION FORM**

*Enables parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.*

This Emergency Medical Authorization, required by O.R.C. 3313.712, must be on file for each student.

**PLEASE PRINT AND RETURN TO SCHOOL WITHIN 7 DAYS.**

**PLEASE PRINT**

Student's Name \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Student's Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Student ID# \_\_\_\_\_ Teacher \_\_\_\_\_

**Note: Listing individuals below allows your student to be released to those individuals (must be age 18 or over)**

Parent/Guardian's Name \_\_\_\_\_ Relation to student \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell \_\_\_\_\_ Work Ph \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Relation to student \_\_\_\_\_

Home Ph \_\_\_\_\_ Cell \_\_\_\_\_ Work Ph \_\_\_\_\_

List in order person (s) who may be notified and to whom your child may be released if the school cannot reach you:

Name	Relationship	Home Phone	Cell Phone	Work Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Facts concerning the child's medical history including allergies, medications and any physical impairment to which a physician should be alerted \_\_\_\_\_

Doctor to be called \_\_\_\_\_ Phone \_\_\_\_\_

Dentist to be called \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Local Hospital \_\_\_\_\_

**Part 1 - TO GRANT CONSENT**

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 above named doctor or in the event the designated preferred physician 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.

Date \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

**Part 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 \_\_\_\_\_

Date \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_