2002-6-21

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name _____

Address _____

City, State, Zip _____

Phone Number _____ Grade _____

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. *

PART I OR PART II MUST BE COMPLETED

PART I ***(Grants Consent)***

In the event reasonable attempts to contact me at (work phone) _____ (cell phone) _____ or (other parent or guardian) _____ at (phone number) _____ have been unsuccessful, I HEREBY GIVE MY CONSENT for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist) 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 (preferred hospital) _____ or 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 surgery, are obtained prior to the performance of such surgery. (Amended Section 3313.712 of Ohio Law)

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

If your child needs an epipen or inhaler, complete the back of the form. A consent for medication form must also be completed.

List two people – a neighbor or nearby relative -- who will assume temporary care of your child if you cannot be reached:

Name _____

Address_____ Phone # _____

Name _____

Address_____ Phone # _____

_____ _____

Signature of Parent or Guardian Date

PART II ***(Refusal to grant 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 or Guardian Date

(over)

If your child is allergic to bees:

Does the child need an epipen at school? ____yes ____ no

Have you provided an epipen to the school and signed the consent for medication form? * ____ yes ____ no

* Must be on file – available from the school office or nurse

In the event of after school activities, does your child have an epipen available?

Briefly explain what happened when he/she was last stung.

_____

_____

_____

If your child has asthma:

Does he use an inhaler in school?

Will the student carry the inhaler and have you provided the school with the consent for medication form? *

* Must be on file – available from the school office or nurse

Self administer? ____yes ____ no

School Fax Number – 330-788-4511