FCS 64, Rev. 9/2003
Section 3313.712 ORC

FAIRBORN CITY SCHOOLS – EMERGENCY MEDICAL AUTHORIZATION

Student Name ____________ Last ____________ First ____________ MI ____________ Home Phone ____________

Address ____________ street ____________ city ____________ zip ____________ School Attending ____________

Date of Birth ____/____/____ Teacher ____________ Grade ______ Room ______

Father/Guardian ____________ Employer ____________ Work Phone ____________

Email ____________ Cell Phone ____________ Pager ____________

Mother/Guardian ____________ Employer ____________ Work Phone ____________

Email ____________ Cell Phone ____________ Pager ____________

Alternate Contacts: 1) ____________ Phone ____________ (relative/friend)

2) ____________ Phone ____________ (relative/friend)

3) ____________ Phone ____________ (relative/friend)

HEALTH HISTORY

Allergies list ____________

Food Allergies list: ____________

EpiPen prescribed? ☐ No ☐ Yes

Asthma? ☐ No ☐ Yes Is inhaler used? ☐ No ☐ Yes Is inhaler at school? ☐ No ☐ Yes

Bee Sting Allergy? ☐ No ☐ Yes What happens? ____________

EpiPen prescribed? ☐ No ☐ Yes

Diabetic? ☐ No ☐ Yes

Seizures? ☐ No ☐ Yes Medication taken ____________

Heart problem? ☐ No ☐ Yes Describe ____________

List any other recurrent medical problem or unusual illness you would like the nurse to be aware of ____________

Do you need health insurance for your child? ☐ No ☐ Yes

HEALTH HISTORY INFORMED CONSENT

The Disclosure of student health information within the school is limited to the information necessary to serve the student's health or education interest. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for academic success and emergency plans, as determined by the nurse. Parent/Guardian signature ____________ Date ____________

PART I. TO GRANT CONSENT (PART I or PART II must be completed)

I hereby give consent for the following care providers and local hospital to be called:

DOCTOR ____________ Phone ____________

DENTIST ____________ Phone ____________

LOCAL HOSPITAL ____________ Emergency Room Phone ____________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent of (1) the administration of any treatment deemed necessary by above-named doctors, or in event that the designated preferred 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. Facts concerning child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____________

Date ____________ Signature of parent/guardian ____________

Address ____________ City ____________ Zip ____________

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: ____________

Date ____________ Signature of parent/guardian ____________

Address ____________ City ____________ Zip ____________