EMERGENCY MEDICAL AUTHORIZATION
SEC. 3313.712 OHIO REVISED CODE

Westerville City Schools
School District

Students Last Name *First Name*

Sport or Activity

Address

NOTE: This form must be completed for each sport or activity the student is involved in.

( ) -
Telephone

School Attended

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 cannot be reached.

PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at (_____) _____ - _____ *(Phone #)* or _____ *(other parent/guardian)* at (_____) _____ - _____ *(Phone #)* 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; or (2) the transfer of the child to _____ *(preferred hospital)* or any hospital accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medication being taken and any physical impairment to which a physician should be alerted are listed below.

_____

_____

_____

_____/_____/_____
Date Signed

_____
Signature of Parent or Guardian

_____
Address (Same as list at the top of the page.)

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I
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 no action:

_____