

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 complete.*
Asthma No ____ Yes ____ *If yes, Inhaler Authorization Form must be completed.*
Seizures No ____ Yes ____ Emergency seizure medications? _____

Name of medication

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

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