VANDALIA-BUTLER CITY SCHOOLS

Emergency Medical Authorization Form O.P.C.3313.712
20___ - 20___ School Year

School_____ **Date**_____

The purpose of this form is to enable parents/guardians to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when parents or guardians cannot be reached.

Student Name_____ Date of Birth_____ Grade_____

Street Address_____ City_____ State Ohio Zip_____

Parent/Guardian Name_____ Main/Home Phone _____

Parent/Guardian Work Phone_____ Parent/Guardian Cell Phone_____

Signature: Parent/Guardian_____

ADDITIONAL EMERGENCY CONTACT INFORMATION

Parent/ Guardian will always be contacted first in the event of an illness/emergency. Please list in order how additional contacts are to be made when we are unable to reach parent/guardian. If you need to list more than three contacts please attach a separate sheet to this form with the information.

CONTACT 1	CONTACT 2	CONTACT 3
Name_____	Name _____	Name_____
Relationship _____	Relationship _____	Relationship _____
Home Phone _____	Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____	Work Phone _____
Cell Phone/Pager _____	Cell Phone/Pager _____	Cell Phone/Pager_____

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 _____ Insurance_____

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 doctor or by another licensed physician or dentist (providing the designated physician or dentist is not available); 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 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, medications being taken, and any physical impairments to which a physician should be alerted:

_____

This information may be shared with school personnel if it is pertinent to my child's health and safety, educational progress, and/or behavioral management plan.

Signature: Parent/Guardian_____Date:_____
Address:_____

Part II to Not Grant Consent

I DO NOT GIVE CONSENT for emergency medical treatment for my child. In the event of illness or in the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

Signature: Parent/Guardian_____ Date:_____
Address: _____

_____

Vandalia-Butler City School District

PERMISSION FOR FIELD TRIPS

The purpose of this form is to secure permission from parents so that their child/children may participate in Board of Education sponsored field trips. This permission will be for a school year. The classroom teacher will be responsible for notifying the parents prior to all field trips.

Permission is granted for _____to go on field trips under the supervision of a Vandalia-Butler School professional staff member.

Parents will be notified prior to all field trips during the applicable school year.

Signature: Parent/Guardian_____Date_____