EMERGENCY INFORMATION AND MEDICAL AUTHORIZATION
This form must be on file at the school on or before the first day of classes

Student's Name: _____

Home Address: _____

City:_____ Zip:_____ Home Phone #_____

Birth Date: _____ Grade:_____

Mother's Name:_____ Business Telephone # _____

Employers Name :_____Cell Phone #_____

Father's Name:_____ Business Telephone #_____

Employer's Name:_____ Cell Phone # _____

Please list neighbors or nearby relatives who will know your whereabouts and can assume temporary care of your child if you cannot be reached:

Name_____Address:_____Phone:_____

Name_____Address:_____Phone:_____

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Rule 3301-37-05 of the OAC requires school program to secure health information from a child's parent no later than the first day of school. Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

Allergies:_____

Medications currently being administered to the child:_____

Chronic Physical Problems:_____

History of Hospitalizations:_____

Any Limitations:_____

The purpose of the following information: 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. **FILL OUT ONLY PART I OR PART II**

PART I – GRANT TO CONSENT

In the event reasonable attempts to contact me at the numbers listed above have been unsuccessful, I hereby give my consent for: (1) The administration of any medical treatment deemed necessary by (physician) Dr._____ at (phone #)_____ or (Dentist) Dr._____ at (phone #)_____, 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 other hospital reasonably accessible.

This authorization does not cover major surgery unless the medication opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent/Guardian Signature_____Date_____

PART II – REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action but to do the following:

_____

Parent/Guardian Signature:_____Date_____