EMERGENCY MEDICAL AUTHORIZATION
SECTION 3313.712, OHIO REVISED CODE
(Pursuant to Am. H. B. 639)

School District_______________________________ Student's Name__________________________________

School Attended______________________________ Birthdate_______________________________________

Grade____ Social Security #_________________________________

Homeroom #____________ Locker #_____________ Address____

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Telephone______________________________________

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.

Residential Parent or Guardian

Mother's Name_____________________________________ Daytime Phone____________________________

Father's Name_____________________________________ Daytime Phone____________________________

Other's Name______________________________________ Daytime Phone____________________________

Name of Relative or Childcare Provider (to be contacted if parent/guardian unavailable)

____ Relationship______________________________

Address____ Phone____________________________________

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 doctor, 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 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 the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

Allergies - ____

Medications - ____

Physical Impairments - ____

Other Pertinent Information - ____

Date______________________ Signature of Parent/Guardian_________________________________

Address____

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PART II - REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment, I wish the school authorities to take the following action:

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Date______________________ Signature of Parent/Guardian_________________________________

Address____