STUDENT NAME Stevens Alexander 36190
(*Please print*) Last First (ID #)

Centerville City Schools
EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth 1/26/2010
School Driscoll
School Year 2019-2020 Grade 4

Home Phone 937-723-8952
Address 948 New England Ave
City Centerville, OH Zip 45429

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 Samantha Steven Daytime Phone 937-723-8952 Cell 937-272-4511
Father's Name Grant Steven Daytime Phone 431-4315 Cell 271-2466

Emergency Contacts:
1. Janet Fisher / Michael Fisher Daytime Phone 937-429-2151 Cell 937-901-3315
2. Ginny Goerz Daytime Phone _____ Cell _____
3. Michael / Cindy Steven Daytime Phone 937-286-8240 Cell 937-266-8240

Please identify any health concerns that school personnel should be aware of:

Allergies: No ____ Yes ✓ Specify Seasonal, cats
Epi-pen: No ✓ Yes ____ ***If yes, Epi-pen Authorization Form must be completed.***
Asthma: No ✓ Yes ____ ***If yes, Inhaler Authorization Form must be completed.***
Seizures: No ✓ Yes ____ Emergency seizure medications? _____
Name of medications

Diabetes No ✓ Yes Emergency diabetic medications? _____
Name of medications

Does your student take any medication regularly? ___ No ✓ Yes Specify Flonase
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? Migraines causing severe vomiting

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 Dr Robert Myers 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.

Samantha Steven 1/22/19
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

Form Revised 7/087