STUDENT NAME Johnson Coleman 35567
(*Please print*) Last First (ID #)

# Centerville City Schools
# EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth 11/07/08 Home Phone 228-261-1797
School Driscoll Address 815 Stone Lake Dr.
School Year 2019/2020 Grade 5th 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 Jennifer Cass Daytime Phone _____ Cell 228-261-1797
Father's Name _____ Daytime Phone _____ Cell _____
Emergency Contacts:
1. Becky Smith Daytime Phone _____ Cell 302-898-3418
2. Rory Johnson Daytime Phone _____ Cell 937-813-9272
3. Roger Cass Daytime Phone _____ Cell 937-760-5083

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

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

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

Does your student take any medication regularly? X No ___ Yes Specify _____
Name of medication, amount taken, how often

Will your student take medication at school? X 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? None

## 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 Alsey - Primed Phone 937-291-6830
Dentist Almony & Brown Phone 937-529-0042
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

*Form Revised 7/087*