STUDENT NAME Kemp [redacted] Estelle
(*Please print*) Last First (ID #)

Centerville City Schools
EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth 12-29-09 Home Phone 919-698-7265
School Driscoll Address 1040 Kentshire Dr
School Year 2019-2020 Grade 4 City Centerville Zip 45459

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 Emily Kemp Daytime Phone ____ Cell 919-698-7265
Father's Name Michael Kemp Daytime Phone ____ Cell 321-634-2269
Emergency Contacts:
1. Stacey McKenzie Daytime Phone ____ Cell 937-543-9329
2. Hilary Toerner Daytime Phone ____ Cell 937-470-6290
3. Mike Ferris Daytime Phone 937-233-1793 Cell ____

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? No

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 Jennifer Conlon Phone 937-436-2866
Dentist Robert Mazzola Phone 866-8484
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.

Emily Kemp 10/13/19
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