

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose:

Enables parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. This Emergency Medical Authorization, required by O.R.C. 3313.712, must be on file for each student

Parent/Guardian's Name	PLEASE PRINT AND RETURN	TO SCHOOL WITHIN 7 DAYS.			
Student's Name Student's Address Student ID Teacher Date of Birth Student's Address Student's Address Student ID Teacher Date of Birth Student ID Teacher Date of Birth Student ID Teacher Student's Address Student ID Teacher Date of Birth Student ID Teacher Student ID Teacher Date of Birth Student ID Student ID Teacher Parent/Guardian's Name Relation to Student Mork Relation to Student Home Phone Cell Work Parent/Guardian's Name Relations's Name Relations ID Work Relations ID Work Relationship Home Phone Cell Work Relationship Home Phone Cell Phone Work Phone Relationship Home Phone Cell Phone Work Phone Phone Relationship Home Phone Cell Phone Work Phone Phone Date of the College Phone P			Your Email Address		
Student's Address Date of Birth Student ID Teacher Note: Listing individuals below allows your student to be released to those individuals (must be age 18 or over). Parent/Guardian's Name Relation to Student Work List in order person(s) who may be notified and to whom your child may be released if the school cannot reach you: Name Relationship Home Phone Cell Phone Work Phone Facts concerning the child's medical history including allergies, medications and any physical impairment to which a physician should be alerted Doctor to be called Phone Phone Doctor to be called Phone Phone Perferred Local Hospital Part 1 – TO GRANT CONSENT 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 the above named doctor or, in the event the designated preferred hospital is not available, by another licensed physician or dentist and (2) the transfer of the child to any nospital 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. Date Signature of parent/guardian Part 2 – REFUSAL TO CONSENT IDO 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.				- 1	
Date of Birth				Grade	
Parent/Guardian's Name Relation to Student	Student's Address				
Parent/Guardian's Name	Date of Birth	Student ID Teacher			
Parent/Guardian's Name	Note: Listing individuals belo	ow allows your student to be r	eleased to those individuals (must bo	e age 18 or over).	
Parent/Guardian's Name	Parent/Guardian's Name		Relation to Student		
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