

EMERGENCY MEDICAL AUTHORIZATION FORM

Please check one:

O.R.C. 3313.712

NEW

CHANGE

MARYSVILLE EXEMPTED VILLAGE SCHOOLS

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_

Address: \_\_\_\_\_

Number and Street

City, State and Zip Code

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: \_\_\_\_\_ Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Other's Name: \_\_\_\_\_ Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Relative or Childcare Provider:

Name: \_\_\_\_\_ Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_

Number and Street

City, State and Zip Code

Please list acts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: Allergy: \_\_\_\_\_ Type of Reaction: \_\_\_\_\_ Usual Treatment: \_\_\_\_\_

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Medical Condition(s): \_\_\_\_\_

Medications/Treatments: \_\_\_\_\_

Does this child have any condition that could be life-threatening? CHECK ONE: YES  NO

If YES, please explain: \_\_\_\_\_

PART I OR II MUST BE COMPLETED

PART I -- TO GRANT CONSENT

I hereby give consent for the following medical care providers hospital to be called:

Doctor: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

The local emergency squads will transport to Marysville Hospital ONLY

E.R. Phone: ( 937 ) 578-2402

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 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 performances of such surgery.

Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ e-mail \_\_\_\_\_

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: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ e-mail \_\_\_\_\_