

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 HospitaONLY

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 _____