

CIRCLEVILLE CITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION FORM

NOTIFY THE SCHOOL OF ANY CHANGE OF PHONE OR EMERGENCY NUMBERS

School Year _____ Student School ID# _____

School _____ Student's Name _____

Teacher/Grade _____ Address _____

Date of Birth _____

Height _____ Weight _____ Phone Number _____

The following is required by section 3313.712 of the Ohio Revised 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/Step Mother's Name _____ Work Number _____

Father/Step Father's Name _____ Work Number _____

Other Authorized Emergency Contacts

Name _____ Relationship _____

Address _____ Phone Number _____

Name _____ Relationship _____

Address _____ Phone Number _____

PART I – (TO GRANT CONSENT)

I hereby give consent for the following medical care provider's and local hospital to be called:

Doctor _____ Phone Number _____

Dentist _____ Phone Number _____

Medical Specialist _____ Phone Number _____

Local Hospital _____ Emergency Number _____

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 physician 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 any major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Date

Signature of Parent or Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II – (REFUSAL TO GRANT 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 _____

PART III – (EVENT OF EARLY DISMISSAL)

In the event of early dismissal (calamity, etc.), please have an emergency plan worked out with your children and explain to them where they will go. With the nature of dismissal and the number of students, school personnel will be unable to call you. **PARENTS**, please discuss the plan with your child(ren) in advance.

Do you have an emergency plan worked out with your child(ren)? Yes _____ No _____

Date _____ Signature of Parent _____

PART IV (MUST BE COMPLETED ANNUALLY)

**PLEASE COMPLETE CONFIDENTIAL INFORMATION TO BE SHARED
WITH TEACHING STAFF AND EMS IF NECESSARY – If an emergency situation occurs, every
effort will be made to transport to the hospital of choice. But, if necessary, the protocol of the EMS personnel is
to transport to the nearest hospital.**

1. Does your child have **asthma** diagnosed by a physician? Yes _____ No _____ Has your child had any **allergic** reactions to medications, foods, or insects? Yes _____ No _____ If yes, please list the care required _____

2. Has your child been diagnosed as **hyperactive** by your physician? Yes _____ No _____
If yes, please list **Medication, Amount, and Time of Administration** _____

3. Does your child have a seizure disorder as diagnosed by a physician? Yes _____ No _____
If yes, please list **Medication, Amount and Time of Administration** _____

4. Does your child have a cardiac(heart) defect? Yes _____ No _____
If yes, please list any **Restrictions and Medications, Amount, and Time of Administration** _____

5. Has your child been identified as having a **bleeding disorder/tendency**? Yes _____ No _____
If yes, please give diagnosis or description of problem _____

6. Does your child have **diabetes**? Yes _____ No _____
If yes, please list **insulin type, amount, and time given** _____

7. Does your child have a **vision/hearing impairment**? Yes _____ No _____
Wear contacts, contact lenses, or hearing aid(s)/auditory device? _____
8. Any other pertinent medical information or medications being given that could affect your child while in school _____
