CIRCEVILLE CITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION FORM

NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE OR EMERGENCY NUMBERS

Student Name ________________________________________ School __________________________________________
Address ___________________________________________ Telephone ________________________________

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’s Name                  ________________________                       Daytime Phone_______________________
Father’s Name_____________________________________________Daytime Phone_______________________
Other’s Name___________________________________           Daytime Phone_______________________

Name of Relative or Childcare Provider ____________________________________________________________
Relationship_______________________________________________
Address__________________________________________________________Phone_______________________
Name______________________________________ Relationship_______________________________________
Address_________________________________________________________  Phone_______________________

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___________________________________________________ Phone _____________________________
Dentist___________________________________________________ Phone _____________________________
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 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 major surgery unless the medical opinions of two other licensed physicians or
dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child’s medical history including allergies, medications being taken, and any physical
impairments to which a physician should be alerted:
____________________________________________________________________________________________
____________________________________________________________________________________________

Date                  ___________    Signature of Parent/Guardian   Address

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/Guardian   Address

N 14-10
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_____ 
   If yes, please list any treatments given or medication taken______________________________
   ______________________________________________________________________________
   ______________________________________________________________________________

2. Has your child had any allergic reactions to medications, foods, or insects? Yes_____ No_____ 
   If yes, please list the care required__________________________________________________
   ______________________________________________________________________________

3. Has your child been diagnosed as having ADD or ADHD by your physician? Yes_____ No_____ 
   If yes, please list Medication, Amount, and Time of Administration_______________________
   ______________________________________________________________________________

4. Does your child have a seizure disorder as diagnosed by a physician? Yes_____ No_____ 
   If yes, please list Medication, Amount and Time of Administration_______________________
   ______________________________________________________________________________

5. Does your child have a cardiac (heart) defect? Yes_____ No_____ 
   If yes, please list any Restrictions and Medications, Amount, and Time of Administration___________
   ______________________________________________________________________________

6. Has your child been identified as having a bleeding disorder/tendency? Yes_____ No_____ 
   If yes, please give diagnosis or description of problem _______________________________________
   ______________________________________________________________________________

7. Does your child have diabetes? Yes_____ No_____ 
   If yes, please list insulin type, amount, and time given_____________________________________
   ______________________________________________________________________________

8. Does your child have vision/hearing impairment? Yes_____ No_____ 
   Wear glasses, contact lenses, or hearing aid(s)/auditory device?____________________________
   ______________________________________________________________________________

9. Any other pertinent medical information or medications being given that could affect your child while in school__________________________________________________________
   ______________________________________________________________________________