CIRCLEVILLE 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**

SCHOOL: _____

STUDENT'S NAME :_____

PARENT NAME: _____

PARENT'S E-MAIL ADDRESS: _____

PARENTS/GUARDIANS:

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**_____
   _____