STUDENT NAME_____

PLEASE PRINT *FIRST* *MIDDLE* *LAST*

Preble Shawnee Local School
EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio revised code 3313.712)

Date of Birth_____ Home Address_____

School Building_____ City_____ zip _____

Grade Level _____Bus No._____ Homeroom Teacher_____home phone_____

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. This information will be shared , as necessary, with teachers, bus drivers, administrative staff, health personnel, including student nurses, and other school personnel.

Residential Parent or Guardian

Student lives with (please circle) Father & Mother Mother only Father only Shared parenting Other explain_____

Mother's name_____Address_____cell_____

Mother's employment_____work/home_____email_____

Father's name_____Address_____cell_____

Father's employment_____work/home_____email_____

Step Mother's name_____work/home_____cell_____

Step Father's name_____work/home_____cell_____

Name of Relative or Childcare Provider_____relationship_____

Address_____phone_____

List below the names of all brothers and sisters at home or in school. Please list age and grade level.

_____ _____ _____

_____ _____ _____

List 3 names of local persons to be contacted in the event of an emergency OTHER THAN PARENTS

Name_____ Relationship_____Cell/Home (circle)_____

Name_____ Relationship_____Cell/Home (circle)_____

Name_____ Relationship_____Cell/Home (circle)_____

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child at school

Medical Information Past/Current)_____

All Medications (home/School) _____

Allergies (Medical/Food/Other)_____

PART 1 OR 2 MUST BE COMPLETED

PART 1 TO GRANT CONSENT

A. I 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 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(2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

B. I authorize the Preble Shawnee Local School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above, to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for each student while the student is at school, participating in a school sponsored function, or is being transported by the school.

_____

Signature of Parent/Guardian Date

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:

_____

_____

_____

_____

_____

SIgnature of Parent/Guardian Date