STUDENT NAME____
(*Please print*) Last First (ID #)

Centerville City Schools

EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth_______________________ Home Phone_______________________

School_______________________ Address_______________________

School Year__________ Grade__________ City _______________Zip________

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

Mother's Name_______________________ Daytime Phone__________ Cell__________

Father's Name_______________________ Daytime Phone__________ Cell__________

Emergency Contacts:
1. _______________________ Daytime Phone__________ Cell__________
2. _______________________ Daytime Phone__________ Cell__________
3. _______________________ Daytime Phone__________ Cell__________

STUDENT HEALTH SECTION MUST BE COMPLETED

Required forms are available from your school nurse or www.centerville.k12.oh.us

[ ] No medical conditions [ ] No allergies [ ] Medication allergy: _______________________

Allergic to: _______________________

[ ] Requires treatment with epi-pen/antihistamine-- ***Emergency Allergy Plan/Epinephrine Authorization required***

[ ] No medication required for allergy treatment-- ***Allergy No Medication Form required***

[ ] **Asthma**

[ ] Requires inhaler/nebulizer at school-- ***Asthma Action Plan/inhaled asthma medication authorization required***

[ ] No inhaler/nebulizer required at school-- ***Asthma/No Medication Plan required***

[ ] Diabetes [ ] Requires Insulin [ ] Requires oral diabetes medications _______________________

[ ] Seizure Disorder Type: _______________________

[ ] Requires Emergency rescue medication-- ***Contact school nurse for care plan. Prescription/Non-Prescription authorization form required***

[ ] No emergency rescue medication require-- ***Contact school nurse for care plan***

[ ] Heart/blood problems: _______________________

[ ] Other (Specify) _______________________

Medications taken at home: _______________________

[ ] Medications to be given at school: _______________________

Requires Prescription/Non-Prescription authorization form

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 above named doctors, or, in the event the designated 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 performance of such surgery.

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Signature of Parent/Guardian Date

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:

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Signature of Parent/Guardian Date

1/2018