EMERGENCY MEDICAL AUTHORIZATION FORM (2015-2016)

HAS YOUR INFORMATION CHANGED FROM THE PREVIOUS YEAR? ☐ YES ☐ NO

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. ***NOTIFY THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES.*** (Ohio Revised Code 3313.712)
(Please print or type – AND SIGN FORM IN THE APPROPRIATE AREA on the reverse side).

TO THE PARENTS/GUARDIAN OF:

_____ ***STUDENT'S NAME*** _____ ***STUDENT ID***

_____ ***STREET ADDRESS*** _____ ***DATE OF BIRTH*** ***GENDER:*** ☐ Female ☐ Male

_____ ***CITY, STATE, ZIP*** _____ ***TELEPHONE #*** ***GRADE/HOMEROOM:*** _____

RESIDENTIAL/CUSTODIAL PARENT or LEGAL GUARDIAN:

Student LIVES with: (please check) and enter information below:

☐ **Father & Mother** ☐ **Mother ONLY** ☐ **Father ONLY** ☐ **Shared Parenting** ☐ **Foster Parent** ☐ **Other** _____

NAME	RELATIONSHIP	FULL ADDRESS (if different than student's)	HOME PHONE	CELL PHONE	WORK PHONE	E-MAIL ADDRESS

Additional space for e-mail address, if needed (indicate name): _____

List three (3) names of persons to be contacted in the EVENT OF AN EMERGENCY:

I understand that my child may be released to anyone on the list if ill, injured, or if an emergency occurs, and he/she must leave school.

NAME	RELATIONSHIP	HOME PHONE	CELL PHONE	WORK PHONE

MEDICAL PROBLEMS/ALLERGIES/SPECIAL NEEDS (Please check applicable box):

☐	Diabetes	☐	Bee or Insect Sting (bite)	☐	Hearing Impaired	☐	Emotional Problem	☐	Other
☐	Asthma	☐	Food Allergy	☐	Learning Disability	☐	Visually Impaired	☐	
☐	Seizures	☐	Medication Allergy	☐	Orthopedic	☐	History of Concussion	☐	

Please provide detailed information regarding any above checked items: _____

_____

Medication your child takes daily: _____

*** PLEASE REFER TO BACK PAGE FOR ADDITIONAL INFORMATION AND *REQUIRED SIGNATURES* ***

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you ***DO NOT CONSENT*** for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

PART I OR II MUST BE COMPLETED - *(only complete Part I OR Part II)*

PART I: TO *GIVE* CONSENT ~

A. I hereby *GIVE CONSENT* for the following medical care providers and local hospital to be called:

Doctor: _____ **Phone:**_____

Dentist: _____ **Phone:** _____

Hospital: _____ **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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

B. I authorize Milford Exempted Village 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 such 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**

***** Complete Part II *ONLY* if you have *NOT COMPLETED PART I* *****

PART II: *REFUSAL* to Give Consent ~

I *DO NOT GIVE* my consent for emergency medical treatment for 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**