Students
5341 F1
Revised 4/5/10

Dublin City School District

Emergency Medical Authorization Form

Complete Both Sides

Student Name: ____
(Last Name) (First Name) (Middle Initial)

Home Address: ____
(Street) (City/State/Zip) (County)

School Attending: ________________________________ Teacher/Team: __________________________ Grade: _______

Parent(s)/Guardian with whom student resides: ____

Mother: ________________ Home Phone: ______________ Father: _________________ Home Phone: ______________

Work Phone: ______________ Cell Phone: ______________ Work Phone: ______________ Cell 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 with staff and emergency care providers if needed.

In the event you cannot be reached, list two local people to whom you authorize the school to release your ill or injured child.

Name: ____ Name: ____

Home Phone: ______________ Cell Phone: ______________ Home Phone: ______________ Cell Phone: ______________

Work Phone: ___________________________________ Work Phone: ___________________________________

Relationship to Student: ___________________________ Relationship to Student: ___________________________

Please list facts concerning the child's medical history, including allergies, medications being taken, and physical impairments to which a physician should be alerted.

Allergies: ____
(List what your child is allergic to) (Type of reaction) (Usual treatment)

Medical Condition: ____

Medications/Treatment: ___________________________ Physical Impairments: ___________________________

According to ORC 3313.712, a legal parent/guardian must sign either the Consent for Treatment or the Refusal to Consent for Treatment. Please sign EITHER Option I OR Option II (do not sign both):

OPTION I: CONSENT FOR TREATMENT

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

Parent/Guardian Signature: ____________________________

Address: _____________________ Date: ______________

OPTION II: REFUSAL TO CONSENT FOR TREATMENT

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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Parent/Guardian Signature: ____________________________

Address: _____________________ Date: ______________