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.

_____

Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of m child. In the event of illness or injury requiring emergency treatment, wish the school authorities to take the following action:

_____

_____

_____

_____

_____

_____

Signature of Parent/Guardian Date

1/2018