EMERGENCY MEDICAL AUTHORIZATION PERMIT

STUDENT'S NAME _____
LAST FIRST MIDDLE INITIAL RACE STUDENT'S CELL PHONE NUMBER

STUDENT'S MAILING ADDRESS _____
STREET CITY ZIP CODE

PRIMARY CONTACT NUMBER _____ DATE OF BIRTH_____ GENDER_____

ASSOCIATE SCHOOL_____ GRADE_____ CAREER TECH PROGRAM _____

OHIO LAW requires this form to be completed and returned each year. 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.

PLEASE NOTIFY THE HIGH SCHOOL OFFICE OF ANY CONTACT REVISIONS THROUGHOUT THE YEAR

The following information is needed to contact the parent or guardian for school related business. Please identify the residential parent or guardian by placing a check mark in the appropriate box below.

☐ Father's Name _____ Mailing Address _____
Cell Phone _____ Home Phone_____
Work Phone _____ Email Address _____

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☐ Mother's Name _____ Mailing Address _____
Cell Phone _____ Home Phone_____
Work Phone _____ Email Address _____

☐ Other Name _____ Mailing Address _____
Relationship__ _____ Cell Phone _____ Home Phone_____
Work Phone _____ Email Address _____

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful. I, hereby, give my consent for (1) 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 reasonably accessible hospital. 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**.**

Emergency Contact Information:

Dentist_____ Phone Number_____
Physician_____ Phone Number_____
Medical Specialist _____ Phone Number_____
Local Hospital _____ Phone Number_____

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted: Information needed in the event of an emergency.

_____

_____

Date: _____ Signature of Parent/Guardian _____
Mailing Address _____ Zip _____

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: _____

_____

Date _____ Signature of Parent/Guardian_____
Mailing Address _____ Zip _____

ORC 3313.712

Revised March 8, 2016