

# EMERGENCY MEDICAL AUTHORIZATION FORM



985 Mediterranean Ave.  
Columbus, Ohio 43229

\_\_\_\_\_  
Student Name

Please check here if address has changed from previous year

\_\_\_\_\_  
Address

Telephone \_\_\_\_\_ Grade \_\_\_\_

Daytime Parent/Guardian Email Address \_\_\_\_\_

Parent/Guardian Cell Phone Number \_\_\_\_\_

**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.

Residential Parent or Guardian:

_____ Father's Name	_____ Place of Employment	_____ Daytime Phone Number
_____ Mother's Name	_____ Place of Employment	_____ Daytime Phone Number
_____ Other Responsible Person/Relationship	_____ Address or Place of Employment	_____ Daytime Phone Number
_____ Name of Relative or Child Care Provider	_____ Address and Phone Number	_____ Relationship

My child has permission to be given Tylenol / Advil or generic equivalent, cough drops, throat lozenges and Children's Mylanta when needed.

Yes

No

**Please check this box if your child is currently using an inhaler.** You will be required to complete an authorization form for Self-Medication for Asthma Inhalers. If this box is checked, a form will be sent to you. Any student using an inhaler **MUST** have this form completed and on file in the office.

_____ Physician	_____ Phone
_____ Dentist	_____ Phone
_____ Med. Specialist	_____ Phone
_____ Local Hospital	_____ Emergency Room Phone

**Part I or Part II of this form MUST be completed.** Please be sure to check "To Grant Consent" or "Refusal to Consent" then sign at the bottom of the page.

**PART I: TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospitals to be called: 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 preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonable accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

**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:

\_\_\_\_\_  
Signature of Parent/Guardian  
(required for consent or refusal to consent)

\_\_\_\_\_  
Date