EMERGENCY MEDICAL AUTHORIZATION
PAULDING EXEMPTED VILLAGE SCHOOLS

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.

Student's Name:_____ Birthdate:_____ Teacher/Grade:_____

Home Address:_____ City:_____ State: OH

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other:_____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

___Mother:_____ Home#:_____ Work#:_____ Cell#:_____

___Father:_____ Home#:_____ Work#:_____ Cell#:_____

___Other:_____ Home#:_____ Work#:_____ Cell#:_____

List the names of those to whom the child may be released from school, if unable to contact any of the above.

Name/Relationship:_____ Home#:_____ Work#:_____ Cell#:_____

Name/Relationship:_____ Home#:_____ Work#:_____ Cell#:_____

Name/Relationship:_____ Home#:_____ Work#:_____ Cell#:_____

COMPLETE ONLY ONE OF THE FOLLOWING: **I.** Consent for Treatment **OR** **II.** Refusal to Consent

I. CONSENT FOR TREATMENT:

I hereby grant consent for the following medical care providers and local hospital to be called:

*Preferred Physician:*_____

Office #:_____

*Preferred Dentist:*_____

Office #:_____

*Medical Specialist:*_____

Office #:_____

Preferred Hospital*:*_____

ER #:_____

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:

_____

_____

_____

_____

Parent/Guardian
Signature:_____
Date:_____
Address:_____

_____
Date:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by the preferred doctor indicated, 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.

MEDICAL HISTORY: Facts concerning the child's medical history including all allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted:

Allergies:_____

_____

Chronic Health Problems:_____

_____

Medications:_____

_____

My child has permission to take the following medications at school (check all that apply):

_____ Non-aspirin pain reliever (Tylenol) _____ Do not give any medications to my child

_____ Cough drops

_____ Antacids

Parent/Guardian Signature:_____Date:_____