☐ *Please check if address/information needs updated in office*

CRESTVIEW LOCAL SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION

For office use only

Purpose: To enable parents/guardians to **AUTHORIZE EMERGENCY TREATMENT** for children who become ill or injured while under school authority, when parents cannot be reached. Reference O.R.C. 3313.712

(Please print!)

Student Name: _____ Date of Birth: _____ Grade _____ Bus # _____

Student's Address: _____ City _____ State _____ Zip _____

Phone Number: _____

The legal guardian(s) for this student is/are: _____

List the names, relationship to the student, and phone numbers of those people the school should call in the event of accident or illness. This list should include the parent(s)/legal guardian(s) if they are to be contacted, and should be in the order of calling preference.

Parent(s) Email Address: _____

Name	Relationship	Home Phone	Work Phone	Cell Phone/Pager

I understand that my child may be released to anyone on the above list if he/she becomes ill or injured and must leave school.

_____ _____

Signature of Parent/Legal Guardian Date

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you do not consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Specialist: _____ Phone: _____
Hospital (1st choice) _____ (2nd choice) _____

Please complete EITHER Part I or Part II below:

Part I: Grant Consent

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 the previously-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 other licensed physicians or dentists, 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: (i.e. asthma, diabetes, bee stings allergy, seizures) _____.

_____ _____

Signature of Parent/Legal Guardian **Date**

Part II: Refusal to consent (DO NOT COMPLETE IF YOU COMPLETED PART I).

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: **(MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)**

_____

_____

_____ _____

Signature of Parent/Legal Guardian Date