Print Form

EMERGENCY MEDICAL AUTHORIZATION

Insurance Company:	**Policy Number:**
Self Pay: ☐ **Yes** ☐ **No**	

Student Name

Home School

Student Address

Teacher/Grade

City, State, Zip Code

Date of Birth

Emergency Contact Telephone Number

Emergency Contact Cell Phone Number

PART I OR PART II MUST BE COMPLETED

In the event reasonable attempts to contact me at _____(phone number) of _____, or other parent or guardian at _____(phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred physician) or Dr._____(preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; also the transfer of the child to _____(preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring 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 impairments to which a physician should be alerted:

Signature of Parent or Guardian

Address

Date

COMPLETE ONLY IF REFUSING MEDICAL TREATMENT FOR STUDENT

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 no action or to:_____

Date

Signature of Parent or Guardian

Address

Section 3313.712, Ohio Revised Code
(Pursuant to Am. H. B. 1175)