

Due 1<sup>st</sup> Day of School  
C.C.S. EMERGENCY MEDICAL AUTHORIZATION

Student Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father /Guardian: \_\_\_\_\_  
Name Place of Employment Work phone Car/Cell phone Pager

Mother/Guardian: \_\_\_\_\_  
Name Place of Employment Work phone Car/Cell phone Pager

Medical Insurance carrier \_\_\_\_\_ Policy number \_\_\_\_\_ Policy holder \_\_\_\_\_

**Ohio Revised Code #3313.71**

**MEDICAL INFORMATION**

(Please do not list any information that you wish to remain confidential. Any confidential information should be listed on an attached sheet only. Thank you.) Attached sheet \_\_\_\_\_ Yes \_\_\_\_\_ No

Does your child have any current medical condition: \_\_\_\_\_

Past medical, emotional or surgical conditions (i.e. frequent upper respiratory infections, depressions, or cardiac surgery)  
\_\_\_\_\_

Currently on daily medications \_\_\_\_\_

Allergies: PLEASE LIST ALL ALLERGIES—including food, drugs, environmental. Rank frequency, severity and give details if emergency treatment may be required of if a physician should be alerted.

Is there any other information that would be helpful to a health professional in case of an emergency?  
\_\_\_\_\_

PERSON TO CALL IF PARENT CANNOT BE REACHED- 1. \_\_\_\_\_  
Name Phone Relationship  
2. \_\_\_\_\_ 3. \_\_\_\_\_  
Name Phone Relationship

**Part I (To Grant Request)**

In the event that I cannot be contacted, I hereby give consent for the administration of any treatment deemed necessary by preferred physician Dr. \_\_\_\_\_ PH# \_\_\_\_\_ or preferred Dentist Dr. \_\_\_\_\_ PH# \_\_\_\_\_ or in the event the designated preferred practitioner is not available, by another licensed physician or dentist. I also give consent to transfer my 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 in the necessity for such surgery, are obtained before surgery is performed. If emergency transportation is needed, we agree our child may be transported by a privately owned car or by life squad at parent expense. \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Parent Signature Date

**Part II. DO NOT COMPLETE PART II IF YOU COMPLETED PART I.**

I do not give my consent for emergency medical treatment of my child. I wish the school to take no action or to \_\_\_\_\_

\_\_\_\_\_  
Parents Signature