ARLINGTON SCHOOL

Emergency Medical Authorization Form (Ohio Revised Code 3313.712)

2017-2018

Student Name_____

(Please print) ***First*** ***Middle*** ***Last***

Address _____

Street ***P.O. Box*** ***City*** ***State*** ***Zip***

Student's Date of Birth_____ **Grade**_____

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/guardians cannot be reached. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel, and other school personnel.

EMERGENCY CONTACTS: Please list names in the order they should be contacted if parents cannot be reached.

	Name	Home Phone	Cell Phone	Work Place & Phone #
Parent/Mother				
Parent/Father				
Emergency Contact #1				
Emergency Contact #2				
Emergency Contact #3				

It is extremely important that you provide ANY pertinent medical history or information about existing conditions that may affect your child while on the trip.

Medical information:
Medications:
Allergies:

PART 1 OR 2 MUST BE COMPLETED

TO GRANT CONSENT

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

Doctor_____ Phone_____

Dentist _____Phone _____

Local Hospital/Emergency Room_____

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 designed 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 options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____

Signature of Parent/Guardian Date

Actual signature required

Part 2: 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:

_____

_____

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_____

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_____

Signature of Parent/Guardian Date

Actual signature required

5/2017