

EMERGENCY MEDICAL AUTHORIZATION
O.R.C. 3313.712

Hospitalization Insurance:

	_____	Student's Name
Company: _____	_____	Address
Policy Number: _____	_____	Zip: _____
Insured's ID Number: _____	_____	Telephone: (____) _____

Family E-Mail Address: _____ @ _____

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.*

Residential Parent or Guardian

Mother's Name: _____ Cell Phone: (____) _____

Employer Name: _____ Work Phone() _____

Father's Name: _____ Cell Phone:(____) _____

Employer Name: _____ Work Phone: () _____

Other's Name: _____ Cell Phone: (____) _____

Employer Name: _____ Work Phone: () _____

ALTERNATE CONTACTS

Name or Relative or Childcare Provider: _____

Relationship: _____ Daytime Phone: (____) _____

Address: _____ Zip: _____

Name or Relative or Childcare Provider: _____

Relationship: _____ Daytime Phone: (____) _____

Address: _____ Zip: _____

PART I OR PART II MUST BE COMPLETED

(see reverse side)

PART I OR PART II MUST BE COMPLETED
PART I: TO GRANT CONSENT

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

Physician: _____ Phone: (____) _____

Dentist: _____ Phone: (____) _____

Medical Specialist: _____ Phone: (____) _____

Local Hospital: _____ Phone: (____) _____

In the event reasonable attempts to contact me at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, 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 of 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:

Date: _____ Signature of Parent/Guardian: _____

Address: _____

_____ Zip: _____

IF YOU COMPLETED PART I, DO NOT COMPLETE PART II

PART 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:

Date: _____ Signature of Parent/Guardian: _____

Address: _____

_____ Zip: _____