# EMERGENCY MEDICAL AUTHORIZATION FORM
# O.R.C. 3313.712

**School** St. Henry Elementary School **Student Name**_____

**Student Date of Birth:** _____ **Address**_____

**GRADE** PS

**Parent email address:**

_____ **Telephone**_____

(May be used by school personnel for various reasons)

**Parents**: ☐ Married ☐ Divorced ☐ Separated Other, please specify: _____

If divorced/separated/other who is residential parent?_____
**Official paperwork must be on file in the school office.**

Name of non-residential parent: _____

Address of non-residential parent: _____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill, injured while under school authority, or non-emergency incidents when parents or guardians cannot be reached.

**Mother's Name or Guardian**_____ Cell Phone_____

Work Phone_____ Location_____

**Father's Name or Guardian**_____ Cell Phone _____

Work Phone_____ Location_____

**Other's Name**_____ Daytime Phone_____

Relationship_____ Cell Phone_____

**Other's Name**_____ Daytime Phone_____

Relationship_____ Cell Phone_____

***Parents must inform the school of changes in residence, custody, home phone, work and emergency telephone numbers.**

## PART I OR 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:

Doctor_____ Phone_____

Address_____

Dentist_____ Phone_____

Address_____

Medical Specialist_____ Phone_____

**PART I – TO GRANT CONSENT CONT.**

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 doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer and/or emergency transportation 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:

_____

_____

_____

★ _____

Signature of Parent/Guardian Date

**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:

_____

_____

_____

★ _____

Signature of Parent/Guardian Date

**STUDENT DIRECTORY INFORMATION**

I **do not** want any Student Directory Information for my son/daughter to be released to any organization or business without my written consent, except for the following four organizations: colleges/universities, U.S. Military, Newspaper (for honor roll and scholarship recipients), and the St. Henry Catechetical Center (CCD).

**My signature below indicates that I have read the Student Directory Information and completed the Emergency Medical information for this school year.**

★ _____

Signature of Parent/Guardian

★ _____

Signature of Student