EMERGENCY MEDICAL AUTHORIZATION

R.C. 3313.71.2

STUDENT NAME (Last, First, Middle): _____

STREET ADDRESS _____**PO BOX #** _____ **CITY** _____ **ZIP** _____

EMERGENCY PHONE (HOME OR CELL)_____ **OR**_____ **BIRTHDATE** _____

SCHOOL: Etna Kirkersville Pataskala WMS WMHS Grade: _____ Teacher: _____Bus: (AM)____(PM)_____

STUDENT'S CUSTODIAL FAMILY STATUS (check one)

Biological Parental Status: Never Married____ Parents Married ____ Parents Separated ____ Parents Divorced ____ Spouse Deceased ____

STUDENT'S CUSTODIAL FAMILY RESIDENCY INFORMATION (check one)

___Mother & Father ___Mother Only ___Father Only ___Mother & Stepfather ___Father & Stepmother

___Court Appointed Guardian(s)/Grandparent(s) ___Foster Parent ___Host Parent ___Other (specify)____

FEMALE

__Biological Mother __Step-Mother __Indicate Other Relationship_____

Last Name: _____ First Name:_____
Address if different than student's: _____
_____
Home Phone: ( )_____Cell Phone: ( )_____
Email Address: _____
Work Place: _____
Work Place Phone Number: ( )_____Ext._____

MALE

__Biological Father __Step-Father __Indicate Other Relationship_____

Last Name:_____ _First Name:_____
Address if different than student's: _____
_____
Home Phone: ( )_____Cell Phone: ( )_____
Email Address: _____
Work Place: _____
Work Place Phone Number: ( )_____Ext._____

WITH WHOM DOES THE CHILD RESIDE IF DIFFERENT THAN ABOVE? _____

NON-CUSTODIAL PARENT _____MAY BE CONTACTED AT ( ) _____ IF I CANNOT BE REACHED.

IN THE EVENT THAT I CANNOT BE REACHED, I HAVE CONTACTED THE FOLLOWING FRIENDS, NEIGHBORS OR NEARBY RELATIVES WHO HAVE AGREED TO PROVIDE TRANSPORTATION AND ASSUME TEMPORARY CARE OF MY CHILD WHEN A MINOR ILLNESS OR INJURY OCCURS.

1. Name _____ Home Phone ( )_____ Cell Phone ( )_____
2. Name _____ Home Phone ( )_____ Cell Phone( )_____
3. Name _____ Home Phone ( ) _____Cell Phone( )_____

Parent/Guardian Signature_____

KNOWN ALLERGIES: _____
CURRENT MEDICATIONS: _____
HEALTH CONCERNS (Diabetes, Asthma, surgical history etc.): _____
PHYSICAL IMPAIRMENTS: _____
DATE OF LAST TETANUS BOOSTER (IF KNOWN): _____

n event reasonable attempts to contact me _____ at (____)_____or
Other parent _____ at (____)_____
have been unsuccessful, I hereby give my consent for: (1) The administration of any treatment deemed necessary by the practitioner listed below. However, if the practitioner is not available, you may contact another licensed physician or dentist.

Preferred physician _____ at (_____)_____
Preferred dentist _____ at (_____)_____

(2) If necessary, transfer of my child to _____or any hospital reasonably accessible.
preferred hospital

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in necessity for such surgery, are obtained before surgery is performed.

Signature of Legal Guardian_____ Date _____

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 _____
_____

Signature of Legal Guardian _____Date _____

NAME OF BABY-SITTER OR CHILD CARE PROVIDER IF APPLICABLE:

(AM) Name _____ Address _____ Phone ( ) _____

(PM) Name _____ Address _____ Phone ( ) _____

6/12 COPIES TO: SCHOOL OFFICE & TRANSPORTATION