

EMERGENCY MEDICAL AUTHORIZATION

R.C. 3313.71.2

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

In 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 _____

SOUTHWEST LICKING LOCAL EMERGENCY INFORMATION PROCEDURE CARE

STUDENT DATA

Last Name _____ First Name _____ Middle Name _____

Street Address: _____ P.O. Box# _____ City: _____ Zip Code: _____

Home Phone () _____ Unlisted? Yes ___ No ___

SCHOOL: Kdg. Ctr. Etna

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 _____

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

(AM) Name _____ Address _____ Phone () _____

(PM) Name _____ Address _____ Phone () _____