BEREA CITY SCHOOL DISTRICT – EMERGENCY MEDICAL AUTHORIZATION

Student Name ____ **Building** ____

Address ____
Number & Street *City* *Zip*

Telephone ____ **Date of Birth** ____

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 (PLEASE PRINT INFORMATION):

Mother's Name ____ **Mobile Phone** ____

Daytime Phone _____________________________________ **Other Phone** ____

Father's Name ____ **Mobile Phone** ____

Daytime Phone _____________________________________ **Other Phone** ____

Other's Name ____ **Mobile Phone** ____

Daytime Phone _____________________________________ **Other Phone** ____

Name of Relative or Childcare Provider:

____ **Relationship** ____

Address ____

Daytime Phone _____________________________________ **Other Phone** ____

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:

Physician ____ **Phone** ____

Dentist ____ **Phone** ____

Medical Specialist ____ **Phone** ____

Local Hospital ____ **Emergency Room Phone** __________________________________

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 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 impairments to which a physician should be alerted:

____

____

Date ______________________________ **Signature of Parent/Guardian** ____

Address ____

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 ____

Section 3313.712, Ohio Revised Code