

BLANCHESTER LOCAL SCHOOL DISTRICT
Emergency Medical Authorization

Date _____

Grade Level _____

Student's Name _____

Teacher's Name _____

Address _____

Date of Birth _____

P.O. Box _____

Male _____ Female _____

City/State/Zip _____

Home Phone # _____

County _____

Cell Phone # _____

Residential Parent or Guardian:

Mother's Name _____

Cell & Daytime Phone _____

Father's Name _____

Cell & Daytime Phone _____

Live's with _____

Cell & Daytime Phone _____

Purpose: To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school authority when parents or guardians can not be reached. Please list at least 2 (two) persons who you wish to be called, if you can not be reached:

Name Relationship to student Phone number

Name Relationship to student Phone number

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor _____ Phone Number _____

Dentist _____ Phone Number _____

Medical Specialist _____ Phone Number _____

Local Hospital _____ Emergency Room Phone Number _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give 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.

(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.

Medical problems or specials needs: ___Diabetes ___Asthma ___Seizures ___Physical Limitations ___Emotional Problems ___Medication/Food/Bee Stings/Other Allergies ___Severe Allergic Reaction ___Other conditions

Please describe any conditions marked above _____

Current medication(s): _____

Permission granted for school health screenings such as scoliosis, dental, or blood pressure? ___ Yes ___ No

(Exemptions from mandatory hearing and vision screenings require a note from your doctor or optometrist).

Signature of Parent/Guardian _____ Printed Name _____ Date: _____

PART II - REFUSAL TO CONSENT

I DO NOT give 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 _____ Printed Name _____ Date _____