

BEAVERCREEK CITY SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION Revised 5/02

Purpose: To enable parents/guardians to **AUTHORIZE EMERGENCY TREATMENT** for children who become ill or injured while under school authority, when parents cannot be reached. Reference O.R.C. 3313.712. **(Please print! Use a BLACK PEN and press hard)**

Student Name _____ Date of Birth _____ Grade _____
Bus # _____ Student's Address _____ Phone No. _____

The legal guardian(s) for this student is/are _____

List the names, relationship to the student, and phone numbers of those people the school should call in the event of accident or illness. This list should include the parent(s)/legal guardian(s) if they are to be contacted, and should be in the order of calling preference.

Name	Relationship	Home Phone	Work Phone	Cell Phone/Pager
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I understand that my child may be released to anyone on the above list if he/she becomes ill or injured and must leave school.

Signature of Parent/Legal Guardian Date

For educational purposes, special medical problems, physical impairments or other facts concerning your child's medical history may be shared with teachers or other support staff involved in the academic setting. If you do not consent for the sharing of this information, you are required to state this in writing and submit your statement with this form to your school administrator.

Medical Problems/Allergies/Special Needs:

Diabetes Asthma Seizures Bee or Insect Sting Orthopedic Emotional Problem
 Visually or Hearing Impaired Medication or Food Allergy Learning Disability Other

Please provide detailed information regarding any above marked areas:

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Specialist: _____ Phone: _____
Hospital (1st choice) _____ (2nd choice) _____

Please complete EITHER Part I or Part II below:

Part I: Grant Consent

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 the previously-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: _____

Signature of Parent/Legal Guardian Date

Part II: Refusal to consent (DO NOT COMPLETE IF YOU COMPLETED PART I).

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: **(MUST BE COMPLETED IF REFUSING CONSENT FOR TREATMENT)**

Signature of Parent/Legal Guardian Date