EMERGENCY MEDICAL AUTHORIZATION FORM

Fairfield City School District

Student Name_______________________________________School ____________________________

Address____
Street City Zip

Home Phone ( )_______________ DOB____/___/____ Grade_________ Teacher/Team______________________

MOTHER/GUARDIAN:

Name________________________________

Email address ________________________

Home PH:___________Cell PH:___________

Work Place:__________WK PH:___________

FATHER/GUARDIAN:

Name________________________________

Email address ________________________

Home PH:___________Cell PH: ___________

Work Place:__________WK PH: ___________

Phone number to receive recorded Rapid Notification announcements: _______________________________

Is there a legal custody order that applies to this child? Yes______No________**Copy of custody papers must be on file in office**.

If yes, please explain: ____

Is either parent or guardian currently serving in the U.S. Armed Forces? Active Duty ______ Reserve Duty_____ National Guard _______

Emergency Contacts: Please list people to whom you give permission to pick up your child from school. If we are unable to reach you, we will contact the people listed below in the order they are listed. Attach a list if you would like to include more.

	Name	Home #	Cell #	Work #	Relationship to Child
1.	________________	( ) ___________	( ) ___________	( ) ___________	___________
2.	________________	( ) ___________	( ) ___________	( ) ___________	___________
3.	________________	( ) ___________	( ) ___________	( ) ___________	___________
4.	________________	( ) ___________	( ) ___________	( ) ___________	___________

☐ Check the box, if Emergency Contacts are the same as previous school year.

Facts concerning the child's medical history including allergies, medications being taken or current health concerns:

____

____

____

May this health information be shared with appropriate school personnel such as your child's teacher(s)? Yes_______ No________

Date___________Signature of Parent/Guardian__________________________________

COMPLETE **EITHER** PART **I OR** PART II

PART I – CONSENT FOR TREATMENT

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 named doctor, or in the event the designated practitioner is unavailable, 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 to the performance of such surgery.

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

Doctor______________________________Phone ( ) _______________

Dentist______________________________Phone ( ) _______________

Hospital ____

Date___________________

____

Signature of Parent/Guardian

PART II – REFUSAL TO GRANT CONSENT FOR TREATMENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take the following action:

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____

____

Date_________________

____

Signature of Parent/Guardian

Sign only if refusal to consent

Form created per Ohio Revised Code 3313.712 Emergency Medical Authorization. Organization of form modeled after HCSD. 12/11/2018