MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION FORM (2016-2017)

(Ohio Revised Code 3313-712)

STUDENT'S NAME _____ **STUDENT ID#:** _____ **GRADE:** _____

STREET ADDRESS _____ **DATE OF BIRTH:** _____

CITY, STATE, ZIP _____ **PARENT EMAIL:** _____

PURPOSE: To enable parents and guardians to authorize the provisions of emergency treatment or transportation for children who become ill or injured while under school authority, or during an emergency situation, when parents cannot be reached. **IF ANY CHANGES OCCUR, NOTIFY THE SCHOOL IMMEDIATELY.** ***(Please PRINT or TYPE, and SIGN the FORM IN THE APPROPRIATE AREAS.)***

PARENT/LEGAL GUARDIAN:

Student lives with: (please check) and enter information below:

❒**Father & Mother** ❒ **Mother only** ❒ **Father only** ❒ **Shared Parenting** ❒ **Foster Parent** ❒ **Other** _____

NAME	RELATIONSHIP	CELL PHONE	HOME PHONE	WORK PHONE

List three (3) names of people to be contacted in the EVENT OF AN EMERGENCY:

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

NAME	RELATIONSHIP	CELL PHONE	HOME PHONE	WORK PHONE

Please provide detailed information regarding any medical problems, allergies, special needs: _____

_____

Medication your child takes daily: _____

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.

PART I OR PART II MUST BE COMPLETED- *(complete ONE SECTION ONLY)*

PART I: TO GRANT CONSENT

(A) I hereby **GIVE MY CONSENT** for the following medical care providers and local hospital to be called:

DOCTOR: _____ Phone: _____

DENTIST: _____ Phone: _____

HOSPITAL: _____ 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.

(B) I authorize Milford Exempted Village School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for such student while the student is at school, participating in a school sponsored function, or is being transported by the school.

SIGNATURE OF PARENT/LEGAL GUARDIAN/ or STUDENT (IF 18 YEARS OR OLDER) **DATE**

PART II: REFUSAL TO GRANT CONSENT

I **DO NOT GIVE MY CONSENT** for emergency medical treatment for 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/LEGAL GUARDIAN/ or STUDENT (IF 18 YEARS OR OLDER) **DATE**