STUDENT NAME _____
(*Please print*) Last First Middle

Eaton Community Schools
EMERGENCY MEDICAL AUTHORIZATION FORM
(Ohio Revised Code 3313.712)

HAS YOUR ADDRESS OR PHONE INFORMATION CHANGED FROM THE PREVIOUS YEAR?
YES ☐ NO ☐

Date of Birth _____ Home Phone _____
School Building _____ Address _____
Grade Level _____ Bus No. _____ Teacher (Gr. K-6) _____ City _____ Zip _____

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Student lives with (please circle) Father & Mother Mother only Father only Shared parenting Other (explain)_____
Mother's Name _____ Daytime Phone _____ Cell _____
Mother's Place of Employment _____ E-mail address _____
Father's Name _____ Daytime Phone _____ Cell _____
Father's Place of Employment _____ E-mail Address _____
Other's Name _____ Daytime Phone _____ Cell _____
Name of Relative or Childcare Provider _____ Relationship _____
Address _____ Daytime Phone _____

List below the names of all brothers and sisters at home or in school. Please list age, school, and grade level.

_____ _____ _____
_____ _____ _____

List 5 names of persons to be contacted in the event of an emergency (Please include parent(s) names if applicable, and 3 local contacts in order of priority)

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child at school.
Medical Information (Past/Current):
_____
_____
All Medications (Home/School) :_____
_____
Allergies (Medical/Food/Other): _____
_____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Doctor _____ 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.

B. I authorize the Eaton Community 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/Guardian Date

PART II: REFUSAL TO GRANT 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:

_____
_____
_____
_____

_____
Signature of Parent/Guardian Date

Rev. 8/13