EMERGENCY MEDICAL AUTHORIZATION

Annually, the Board of Education will provide to parents or guardians of all students enrolled in the District's schools an Emergency Medical Authorization Form. In the event emergency medical treatment for a student is necessary, the District will adhere to the instructions on the authorization form.

When the form is returned, it shall be kept on file and will be sent to any school district to which a student is transferred. Upon request of a parent, the District may permit the parent to make changes to the previously filed form or to file a new form.

If a parent does not wish to give such written permission, the parent shall indicate on the form the procedure the school is to follow in the event of a medical emergency involving the parent's child.

Any time a student or a group of students is taken out of the District to participate in a school event, the staff in charge of the event must take the Emergency Medical Forms for those students. This includes, and is not limited to, students involved in music trips, athletic trips, field trips, and academic contests. This does not include student spectators at events.

LEGAL REFS: O.R.C. §3313.712

Revised: September 30, 2010

EMERGENCY MEDICAL AUTHORIZATION

Toronto City School District

Date _____ Student Name

Please complete the following and return by September 15

Address

Telephone

School Attended Grade

PURPOSE: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

PART I or PART II MUST BE COMPLETED.

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent) at _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), 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 _____ (preferred hospital) or 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 BEFORE the surgery IS PERFORMED.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____.

Date: _____ Signature of Parent

Address

NOTE: Alternate person _____ _____ to be
(Name) (Relationship)

notified in case of illness. _____ (phone number)

IF YOU DID NOT COMPLETE PART I, PLEASE SEE PART II ON REVERSE SIDE.

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II (Refusal to 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 no action or to:

_____

_____

_____

Date: _____ _____
Signature of Parent

_____
Address

Toronto City School District

Emergency Medical Authorization Form (Ohio Revised Code 3313.712)

Please complete and return as soon as possible.

School Year _____ **School** _____ **Grade** _____

Student Name _____ **Date of Birth** _____

Address _____ **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. Please list contacts in order of preference.

EMERGENCY CONTACTS: Please list names in the order they should be contacted if parents cannot be reached.

	Name	Relationship	Home Phone	Cell Phone	Work Phone
Parent					
Parent					
Contact #1					
Contact #2					
Contact #3					

It is extremely important that you provide ANY pertinent medical history or information about existing conditions that may affect your child at school. A medical alert list will be compiled and shared with school personnel informing them of students who have medical conditions such as asthma, allergies, epilepsy, limited communication/mobility, etc. All staff will be held responsible for handling the medical alert list confidentially. If you do not wish for your student to be added to this list please attach a note stating your refusal and your student will not be added.

Medical Information:

Medications:

Allergies:

PART 1 OR PART 2 MUST BE COMPLETED (NOT BOTH)

PART 1: TO GRANT CONSENT: I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:_____ **Phone:**_____

Dentist_____ **Phone:**_____

Specialist:_____ **Phone:**_____

Doctor:_____ **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.

_____ _____

Signature of Parent/Guardian Date

PART 2: REFUSAL TO CONSENT

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

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date