

**Emergency Medical
Authorization Form
Campbell City Schools**

www.campbell.k12.oh.us

Please print clearly

School: _____
Grade: _____
Custody Alert: _____



Student Name: _____ Birth date: _____

Address: _____ Home Phone: _____

Student lives with (check all that apply): Mother Father Stepfather
 Stepmother Grandmother Grandfather
 Legal Guardian Other Please Specify: _____

Who has legal custody of the child (please X one): Both Parents Mother Only Father Only
 Shared Other: _____ (Please provide legal documents if available.)

Anyone listed on the form is authorized to pick up student from school and may be contacted in the event of a medical emergency

<p><u>Mother</u> Name: _____ Relationship to Student (other please specify): _____ Phone Number: _____ What language(s) do you speak: _____</p>	<p><u>Father</u> Name: _____ Relationship to Student (other please specify): _____ Phone Number: _____ What language(s) do you speak: _____</p>
<p>Are you currently in the Military National Guard or Reserve? _____ Are you active duty? _____ Parent/Guardian Email Address: _____</p>	<p>Are you currently in the Military National Guard or Reserve? _____ Are you active duty? _____ Parent/Guardian Email Address: _____</p>

Other Authorized Contacts (minimum of 3) Able to pick up/remove student from school

Name	Relationship	Language Spoken	Phone Number

Name and grade of siblings attending Campbell City Schools

Name: _____ Grade: _____
 Name: _____ Grade: _____
 Name: _____ Grade: _____



Student Name: _____ Birthdate: _____

Students Health Alerts: Allergies, Medications, Physical impairments, or relevant medical history:

___ Asthma ___ Inhaler ___ Diabetes ___ Seizures ___ Food Allergies ___ Medication Allergies ___ Bee Sting ___ Epipen
___ OTHER Please explain _____

The school nurse may administer, including but not limited to, (1-2) Tylenol, Ibuprofen, Stomach aid & or cough drops to my son/daughter in the event my child's symptoms indicate a need.

Circle one: YES / NO

☆ Signature of Parent/Guardian: _____ Date: _____

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: _____

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. 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/Guardian: _____ Date: _____

PART 2 - 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 the following action: _____

Signature of Parent/Guardian: _____ Date: _____