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

Mother **Name**:____ **Relationship to Student (other please specify):**_____________ **Phone Number:** ______________________________ **What language(s) do you speak:** ____________________	**Father** **Name:**____ **Relationship to Student (other please specify):**_____________ **Phone Number:**______________________________ **What language(s) do you speak:** ____________________
Are you currently in the Military National Guard or Reserve?________ **Are you active duty?**______ **Parent/Guardian Email Address:**	**Are you currently in the Military** National Guard or Reserve?________ **Are you active duty?**______ **Parent/Guardian Email Address:**

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

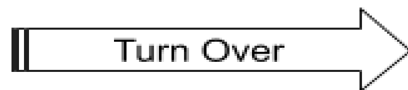
Name	Relationship	Language Spoken	Phone Number

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______________________

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____

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:______________**

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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:___________________**

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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:____________________