BUCKEYE VALLEY LOCAL SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

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 may be shared with persons responsible with the care of my child.

Student's Name: _____ Birthdate: _____ Grade: _____

Home Address: _____ Teacher/Homeroom: _____

City/State/Zip: _____ Date of Last Tetanus: _____

Student resides with (circle all that apply) Mother Father Stepparent Guardian Other: _____

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd):

____ **Parent/ Guardian:** Name _____ Email Address: _____
Address _____
Home # _____ Cell # _____ Work # _____

____ **Additional Contact:** Name _____ Email Address: _____
Address _____
☐ **N/A** Home # _____ Cell # _____ Work # _____

____ **Additional Contact:** Name _____ Email Address: _____
Address _____
☐ **N/A** Home # _____ Cell # _____ Work # _____

____ **Additional Contact:** Name _____ Email Address: _____
Address _____
☐ **N/A** Home # _____ Cell # _____ Work # _____

COMPLETE ONLY ONE OF THE FOLLOWING: **I. Consent for Treatment** ***OR*** **II. Refusal to Consent**

I. CONSENT FOR TREATMENT
I hereby give consent for the following medical Care providers and local hospital to be called:

Preferred Physician: _____
Office #: _____
Preferred Dentist: _____
Office #: _____
Medical Specialist: _____
Office #: _____
Preferred Hospital: _____
ER #: _____

II. REFUSAL TO CONSENT
I do NOT give 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:

_____
_____
_____
_____

Parent/Guardian: _____
Address: _____
_____ Date: _____

AND

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 the preferred doctor indicated, or, in the event the designated preferred practioner 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.

Parent/Guardian Signature: _____ Date: _____

****The State of Ohio is now mandating that school districts collect ethnicity and race information on every student in their district. ****
Please complete the following:

ETHNICITY/RACE

ETHNICITY (choose one)
_____ Hispanic/Latino
_____ Not Hispanic/Latino

RACE (choose one or more, regardless of ethnicity)
_____ American Indian or Alaska Native
_____ Asian
_____ Black or African American
_____ Native Hawaiian or Other Pacific Islander
_____ White

(PLEASE COMPLETE BOTH SIDES)

Student Name: _____

Medical History- Please check any that child has had:

_____ Abnormal spinal curvature (scoliosis, etc.)
_____ ADHD/ADD
_____ Allergy
_____ Anemia
_____ Asthma or wheezing
_____ Bedwetting at night_____ during day _____
_____ Behavior problems
_____ Birth defect
_____ Cancer, type _____
_____ Chicken Pox
_____ Chronic diarrhea or constipation
_____ Chronic cough
_____ Concern for relations with siblings or friends
_____ Cystic Fibrosis
_____ Diabetes
_____ Eczema
_____ Emotional/depression/anxiety disorder
_____ Ear problems, poor hearing
_____ Eating disorders
_____ Eye problems, poor vision
_____ Frequent headaches
_____ Frequent skin infections
_____ Frequent sore throat infections
_____ Heart Disease, type _____
_____ Hepatitis
_____ HIV/AIDS
_____ Joint problems or arthritis
_____ Kidney disease, type _____
_____ Near drowning/suffocation
_____ Nervous twitches or tics
_____ Painful menstrual cramps
_____ Pregnancy
_____ Rheumatic fever
_____ Seizures or epilepsy
_____ Self hurt behaviors
_____ Sickle cell anemia
_____ Stool Soiling (encoporesis)
_____ Substance abuse (alcohol/drugs)
_____ Suicide attempt
_____ Toothache or dental infections
_____ Urinary tract infections
_____ Other _____
_____ Other _____

During the past 3 years:

Any hospitalizations: Yes/No Explain: _____

Any illness lasting more than a week: Yes/No Explain: _____

Any injuries requiring medical attention: Yes/No Explain: _____

When did your child last see the doctor? _____ Why? _____

When did your child last see the dentist? _____ Why? _____

Allergies- Please list and describe allergies and reactions to:

Allergic To	Reaction Observed	Treatment
Medicine: ☐ N/A		
Foods: ☐ N/A		
Insects/other: ☐ N/A		

Medications/Medical Procedures: ☐ N/A

Daily Medications
Medications given frequently, but not daily
Procedures needed at school (sugar testing, etc.)
Accommodations requested at school due to a health concern or disability

Parent/Guardian Signature: _____ Date: _____

PF1 Adopted 2/09
Revised 2/14