

**Emergency Medical Authorization Form O.P.C.3313.712**

20\_\_ - 20\_\_ School Year

School \_\_\_\_\_ Date \_\_\_\_\_

The purpose of this form is to enable parents/guardians to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when parents or guardians cannot be reached.

 Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State Ohio Zip \_\_\_\_\_  
 Parent/Guardian Name \_\_\_\_\_ Main/Home Phone \_\_\_\_\_  
 Parent/Guardian Work Phone \_\_\_\_\_ Parent/Guardian Cell Phone \_\_\_\_\_  
 Signature: Parent/Guardian \_\_\_\_\_

**ADDITIONAL EMERGENCY CONTACT INFORMATION**

Parent Guardian will always be contacted first in the event of an illness emergency. Please list in order how additional contacts are to be made when we are unable to reach parent guardian. If you need to list more than three contacts please attach a separate sheet to this form with the information.

CONTACT 1	CONTACT 2	CONTACT 3
Name _____	Name _____	Name _____
Relationship _____	Relationship _____	Relationship _____
Home Phone _____	Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____	Work Phone _____
Cell Phone/Pager _____	Cell Phone/Pager _____	Cell Phone/Pager _____

**PART I OR II MUST BE COMPLETED**
**Part I 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 _____	Insurance _____

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 by another licensed physician or dentist (providing the designated physician or dentist is not available); 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 dentist, 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

This information may be shared with school personnel if it is pertinent to my child's health and safety, educational progress, and or behavioral management plan

 Signature: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Part II to Not Grant Consent**

I DO NOT GIVE CONSENT for emergency medical treatment for my child. In the event of illness or in the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

 Signature: Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Vandalia-Butler City School District**  
**PERMISSION FOR FIELD TRIPS**

The purpose of this form is to secure permission from parents so that their child/children may participate in Board of Education sponsored field trips This permission will be for a school year. The classroom teacher will be responsible for notifying the parents prior to all field trips.

Permission is granted for \_\_\_\_\_ to go on field trips under the supervision of a Vandalia-Butler School professional staff member.

Parents will be notified prior to all field trips during the applicable school year.

Signature: Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_