

TRIAD LOCAL SCHOOL DISTRICT 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.

School: H.S. M.S. E.S. Student Name: _____
 Student Grade Level: _____ Address: _____
 Teacher/Homeroom: _____ (E.S. Only) City: _____ Zip: _____
 Bus Number (A.M.): _____ Phone (Home) _____
 Bus Number (P.M.): _____ Phone (Work) _____

Legal Residential Parent or Guardian:

Name: _____ Phone (Home) _____
 Relationship to Child: _____ Phone (Work) _____
 Legal Custodian: YES NO Phone (Cell) _____

FILL OUT PART I TO CONSENT OR PART II TO REFUSE MEDICAL TREATMENT FOR YOUR CHILD**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: _____ 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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

My child is permitted to take Tylenol while at school if the nurse deems necessary. Yes No

My child is permitted to take cough drops while at school if the nurse deems necessary. Yes No

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

Triad Local School District plans to release special medical conditions (such as allergies and asthma information) to pertinent school staff members such as the school nurse, teachers, bus driver, coaches, etc. for the safety of your child.

My child's medical information may be given to pertinent staff members such as school nurse, teachers, coaches, etc.

DO NOT release my child's information. (Marking this box denies child access to field trips, athletics and extra-curricular activities.)

Date: _____ Signature of Parent / Guardian: _____

Address: _____ City: _____ Zip Code: _____

Continue completion on this form on the reverse side.

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 the following action:

Date: _____ Signature of Parent / Guardian: _____

Address: _____ City: _____ Zip : _____

R.C. 3313.72

PART III - SUPPLEMENTAL INFORMATION

Student's Date of Birth: - - mm - dd - yyyy

Date of Last Tetanus: - - mm - dd - yyyy

Student resides with (check all that apply): Mother Father Step Parent Guardian Other: _____

If custody situation results in child living at different location on different days or during certain parts of the year, please explain:

Additional Contact Information for those **who have authority** to make decisions in an emergency situation involving this student. Please provide information for those individuals that have this authority **ONLY**.

Mother _____ Home #: _____ Work #: _____ Mobile #: _____

Father: _____ Home #: _____ Work #: _____ Mobile #: _____

Step Parent _____ Home #: _____ Work #: _____ Mobile #: _____

Guardian: _____ Home #: _____ Work #: _____ Mobile #: _____

Alternate: _____ Home #: _____ Work #: _____ Mobile #: _____

(Relative or child care provider)

The persons listed below are permitted to sign out your child from school. If a person is not listed, they will not be permitted to sign your child out without further consent from you.

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Date: _____ Signature of Parent / Guardian: _____

Address: _____ City: _____ Zip Code: _____

***** IMPORTANT! If ANY information on this form should change during the school year, it is IMPERATIVE that you inform the school secretary as soon as possible, as outdated information could impede the process of obtaining medical help for the child or in reaching the child's parent, guardian, alternate, etc.**

Make copies of this form and submit to: Transportation Office, Building Secretary, School Nurse

***See PART 1 for permission to make copies for other pertinent staff members.*