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	**Father**
Name:_____	**Name:**_____
Relationship to Student (other please specify):_____	**Relationship to Student (other please specify):**_____
Phone Number: _____	**Phone Number:**_____
What language(s) do you speak: _____	**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:** _____

Turn Over

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:**_____

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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:**_____