

Pleasant Local Schools

Emergency Medical Authorization

Section 3313.712 Ohio Revised Code Mandated by House Bill 639

Student Name _____ Soc. Sec. Num. _____

Address _____

Student Cell Number: _____

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.

Residential Parent or Guardian:

Mother's Name: _____ Daytime phone: _____ Cell #: _____

Father's Name: _____ Daytime phone: _____ Cell #: _____

Other's Name: _____ Daytime phone: _____ Cell #: _____

Name of relative or childcare provider: _____ Relationship: _____

Address: _____ Phone: _____ Cell #: _____

Students involved in any school sponsored athletic activity must have medical coverage.

INSURANCE RELEASE

_____ is covered under Insurance Policy _____ with
Student's Name _____ Policy Number or Name _____

_____ taken out with _____ Therefore, I
Name of Insurance Company _____ Employer or Agent _____

_____ accept full responsibility for _____
Parent or Guardian _____ Student's Name _____

_____ Date _____
Parent or Guardian's Signature _____

Part I or Part 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 _____ ER 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
 - (2) 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: _____

Parent/Guardian Signature _____ Date _____

Address _____

Part II Refusal To Consent

I do not give consent for the 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 SIGNATURE

DATE