PRINCETON CITY SCHOOLS
EMPOWERING EACH STUDENT FOR COLLEGE, CAREER, AND LIFE SUCCESS

Emergency Medical Authorization

In accordance with Ohio Revised Code 3313.712 ORC, new/updated Emergency Medical Authorization forms are required each school year.

Student Name: _____

Date of Birth: _____ **Please Check One: [ ] MALE [ ] FEMALE**

Place of Birth: _____ **Grade/Teacher** _____

Home Address: _____ **Contact #** _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority and/or contacts who are permitted to pick up the above named child if he/she becomes ill or injured, when parents or guardians cannot be reached.

CUSTODIAL PARENT OR GUARDIAN

Name	Home Phone	Cell Phone	Work Phone Ext.

Do mother and father live in the same household? [ ] YES [ ] NO If not, who has legal custody? [ ] MOTHER [ ] FATHER [ ] SHARED [ ] OTHER

EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN TO WHOM STUDENT MAY BE RELEASED IN THE CASE OF A MEDICAL OR OTHER EMERGENCY:

Name	Home Phone	Cell Phone	Work Phone Ext.

Please check any boxes below that are applicable to your child:

□ Asthma: Triggers: _____
Inhaler: [ ] YES [ ] NO

□ Food Allergies: To What: _____
EPI Pen: [ ] YES [ ] NO

□ Insect Allergies: To What _____
EPI Pen: [ ] YES [ ] NO

□ Medications: _____
_____

□ Other Health Conditions/Diseases: _____
_____

□ Diabetes □ Seizures □ Hearing Problems □ Heart Condition
□ Visual Problems □ Modified Diet □ Physical Impairments
□ Mental Health _____

Additional Information/Hospitalizations: _____

**********PART I **OR** PART II MUST BE COMPLETED**********

PART I TO GRANT CONSENT:

DOCTOR TO BE CALLED: _____ Address _____ Phone _____
DENTIST TO BE CALLED: _____ Address _____ Phone _____
MEDICAL SPECIALIST: _____ Address _____ Phone _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-name doctor/dentist/specialist, 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.

Preferred local hospital: _____ Contact #: _____

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: _____ Date: _____
Parent/Guardian Address: _____

***If the student has a medical condition such as allergies, severe asthma, diabetes, heart problems, seizures, an individual student health plan will need to be completed each school year. This health plan will need to be shared with the student's teachers and other school staff for the safety of the student while at school or at a school related activity.**

****Students requiring medication (prescription and non-prescription) at school MUST have a written physician order AND a written parental consent. These forms are available in the school health office. A new form must be completed each school year. Medications must be brought to the school health office in the original container by the parent/guardian, not the student.**

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 no action or to: _____

Signature of Parent/Guardian: _____ Date: _____
Parent/Guardian Address: _____