

STUDENT NAME _____
(Please print) Last First (ID #)

Centerville City Schools

EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Date of Birth _____ Home Phone _____

School _____ Address _____

School Year _____ Grade _____ City _____ Zip _____

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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone _____ Cell _____

Father's Name _____ Daytime Phone _____ Cell _____

Emergency 1. _____ Daytime Phone _____ Cell _____

Contacts: 2. _____ Daytime Phone _____ Cell _____

3. _____ Daytime Phone _____ Cell _____

STUDENT HEALTH SECTION MUST BE COMPLETED

Required forms are available from your school nurse or www.centerville.k12.oh.us

No medical conditions No allergies Medication allergy: _____

Allergic to: _____

Requires treatment with epi-pen/antihistamine-- *Emergency Allergy Plan/Epinephrine Authorization required*

No medication required for allergy treatment-- *Allergy No Medication Form required*

Asthma

Requires inhaler/nebulizer at school-- *Asthma Action Plan/inhaled asthma medication authorization required*

No inhaler/nebulizer required at school-- *Asthma/No Medication Plan required*

Diabetes Requires Insulin Requires oral diabetes medications _____

Seizure Disorder Type: _____

Requires Emergency rescue medication-- *Contact school nurse for care plan. Prescription/Non-Prescription authorization form required*

No emergency rescue medication require-- *Contact school nurse for care plan*

Heart/blood problems: _____

Other (Specify) _____

Medications taken at home: _____

Medications to be given at school: _____

Requires Prescription/Non-Prescription authorization form

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I 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

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:

Signature of Parent/Guardian

Date