

Gahanna-Jefferson Public Schools - High School - Emergency Medical Authorization  
Required by Section 3313.712 of the Ohio Revised Code

**Student Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: M/F Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

**Parent or Legal Guardian Information:**

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Daytime phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_ Daytime phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Physical or Medical Conditions: (examples-asthma, seizures, developmental/cognitive/emotional disorder)

Allergies: \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Treatment: \_\_\_\_\_

Current Medications: include dose and frequency (at home and school)

Please list any exclusions of service for EMS/hospital personnel (i.e. no blood or blood products):

**MEDICAL AUTHORIZATION- Complete only Part I or Part II**

**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.

**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 \_\_\_\_\_

**Part I - To Grant Consent**

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.

(Consent) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If you completed and signed Part I to grant consent do not complete Part II**

**Part II - Refusal to Grant 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: \_\_\_\_\_

(No Consent) Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_