



MADISON LOCAL SCHOOL DISTRICT

1956 Red Bird Road Madison, Ohio 44057 Telephone (440)428-2166 Fax (440)946-6472

Building Attended (check one)

\_\_\_ MHS \_\_\_ MMS \_\_\_ NES \_\_\_ SES \_\_\_ MPK

EMERGENCY MEDICAL AUTHORIZATION

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ (Area Code) Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ 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 cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Mother's Name \_\_\_\_\_ (Area Code) Day Phone # \_\_\_\_\_ (Area Code) Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ (Area Code) Day Phone # \_\_\_\_\_ (Area Code) Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other's Name (Specify Relationship) \_\_\_\_\_ (Area Code) Day Phone # \_\_\_\_\_ (Area Code) Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

NAME OF RELATIVE OR CHILDCARE PROVIDER:

Name (Specify Relationship) \_\_\_\_\_ (Area Code) Day Phone # \_\_\_\_\_ (Area Code) Cell Phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PART I OR PART II ON REVERSE SIDE OF THIS EMERGENCY MEDICAL AUTHORIZATION MUST BE COMPLETED AND RETURNED PRIOR TO OCTOBER 1 OF THE CURRENT SCHOOL YEAR ACCORDING TO OHIO REVISED CODE § 3313.71.2

(OVER)

**PART I (TO GRANT CONSENT)**

**I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITAL TO BE CALLED:**

\_\_\_\_\_  
**Doctor** (Area Code) Phone Number

\_\_\_\_\_  
**Address** City State Zip

\_\_\_\_\_  
**Dentist** (Area Code) Phone Number

\_\_\_\_\_  
**Address** City State Zip

\_\_\_\_\_  
**Medical Specialist** (Area Code) Phone Number

\_\_\_\_\_  
**Hospital** (Area Code) Phone Number

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 concur in the necessity for such surgery are obtained prior to the performance of such surgery.

Fact concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Guardian

**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:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Guardian