MADISON LOCAL SCHOOL DISTRICT

6741 North Ridge 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 <u>OR</u> PART II ON REVERSE SIDE OF THIS EMERGENCY MEDICAL AUTHORIZATION <u>MUST</u> BE COMPLETED AND RETURNED PRIOR TO OCTOBER 1 OF THE CURRENT SCHOOL YEAR ACCORDING TO OHIO REVISED CODE § 3313.71.2

(OVER)

My son/daughter ______________________________ has my permission to take over the counter medications including but not limited to Tylenol, Ibuprofen, Tums, cough drops. X____

Revised 3/1/13

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:

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Date ______________ Signature of Parent / Guardian ______________

PART II (<u>REFUSAL</u> TO CONSENT)

I <u>DO NOT</u> 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:

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Date ______________ Signature of Parent / Guardian ______________