

EMERGENCY MEDICAL AUTHORIZATION
R.C. 3313.71.2

STUDENT NAME (Last, First, Middle): _____

KNOWN ALLERGIES: _____

CURRENT MEDICATIONS: _____

HEALTH CONCERNS (Diabetes, Asthma, etc.): _____

PHYSICAL IMPAIRMENTS: _____

DATE OF LAST TETANUS BOOSTER (if known): _____

.....

In the event reasonable attempts to contact me _____ at _____ or
other parent _____ at _____

have been unsuccessful, I hereby give my consent for: (1) The administration of any treatment deemed necessary by the practitioner listed below. However, if the practitioner is not available, you may contact another licensed physician or dentist.

preferred physician _____ at _____

preferred dentist _____ at _____

(2) If necessary, transfer of my child to _____ or any hospital reasonably accessible.

preferred hospital

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in necessity for such surgery, are obtained before surgery is performed.

Signature of Legal Guardian _____ Date _____

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 Legal Guardian _____ Date _____

SOUTHWEST LICKING LOCAL EMERGENCY INFORMATION PROCEDURE CARD

STUDENT NAME _____ SCHOOL _____

LAST FIRST, MIDDLE

GRADE/TEACHER _____

POST OFFICE BOX NUMBER _____

BUS # _____

STREET ADDRESS _____ APT/LOT # _____

BIRTHDATE _____

CITY _____ ZIP CODE _____ SOCIAL SECURITY # _____

PHONE NUMBER _____ AREA CODE _____ PHONE NUMBER IS UNLISTED: YES NO

CUSTODIAL PARENT OR GUARDIAN NON-CUSTODIAL OR GUARDIAN SHARED CUSTODY SINGLE PARENT

MOTHER'S NAME _____ HOME PHONE _____

WORK PLACE _____ WORK PHONE _____

FATHER'S NAME _____ HOME PHONE _____

WORK PLACE _____ WORK PHONE _____

NAME(S) OF LEGAL GUARDIAN _____

WITH WHOM DOES THE CHILD RESIDE IF DIFFERENT THAN ABOVE? _____

NON-CUSTODIAL PARENT _____ MAY BE CONTACTED AT _____ IF I CANNOT BE REACHED.

IN THE EVENT THAT I CANNOT BE REACHED, I HAVE CONTACTED THE FOLLOWING FRIENDS, NEIGHBORS OR NEARBY RELATIVES WHO HAVE AGREED TO PROVIDE TRANSPORTATION AND ASSUME TEMPORARY CARE OF MY CHILD WHEN A MINOR ILLNESS OR INJURY OCCURS .

1. NAME _____ PHONE _____

2. NAME _____ PHONE _____

3. NAME _____ PHONE _____

PARENT'S/GUARDIAN'S SIGNATURE

NAME OF BABY-SITTER OR CHILD CARE PROVIDER IF APPLICABLE:

(AM) NAME _____ ADDRESS _____ PHONE _____

(PM) NAME _____ ADDRESS _____ PHONE _____