

Student Name \_\_\_\_\_  
(Please print) Last First SIS ID#

Bus # _____
<input type="checkbox"/> Walker
<input type="checkbox"/> Car Passenger
<input type="checkbox"/> Car Driver

**Anthony Wayne Local 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/Pager \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Other Emergency Contacts:

1.	_____	Daytime Phone _____	Cell/Pager _____
2.	_____	Daytime Phone _____	Cell/Pager _____
3.	_____	Daytime Phone _____	Cell/Pager _____

It is extremely important that you provide ANY pertinent medical history or information about existing conditions that may affect your child at school.

**Medical Information:**

\_\_\_\_\_

**Medications:**

\_\_\_\_\_

**Allergies:**

\_\_\_\_\_

**PART 1 OR 2 MUST BE COMPLETED**

**PART 1: TO GRANT CONSENT**

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 \_\_\_\_\_

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 doctors, or, in the event the designed 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 options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

**PART 2: 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 \_\_\_\_\_