TORONTO CITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION FORM
(Ohio Revised Code 3313.712)

Date _____ _____
Student Name

SS# _____ _____
Address

Birthdate _____ _____
Telephone

Weight _____ _____ _____
School Grade

Please complete the following and return to school as soon as possible.

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, coaches, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider _____

Address _____ Phone _____ Relationship _____

PART I OR II MUST BE COMPLETED

PART I - 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 _____ PHONE _____

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 the above-named doctor, or, in the event the designated preferred practitioner is not available, by other 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.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician or school personnel should be alerted:

_____

_____

_____

A medical alert list will be compiled and shared with school personnel informing them of students that have medical conditions that they should be aware of such as: asthma, allergies, epilepsy, hemophilia, limited communication/mobility, etc. All staff will be held responsible for handling the medical alert list confidentially. If you do not wish for your student to be added to this list please attach a note stating your refusal and your student will not be added.

Date _____ Signature of Parent/Guardian _____

Address _____

IF YOU DID NOT COMPLETE PART I, PLEASE SEE PART II ON REVERSE SIDE

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 or Guardian

_____
Address

_____
Phone

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