

Tiffin City Schools
EMERGENCY MEDICAL AUTHORIZATION FORM
 (Ohio Revised Code 3313.712)

Student's Name _____
 (Please print) *Last* *First* *Middle Initial*

Student's Address _____ Currently living with Father Mother
 Other _____

Phone # _____ Grade _____

Student's Date of Birth _____

Parent/Guardian e-mail _____

School Year _____

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.

EMERGENCY CONTACTS: Please list names in the order they should be contacted if parents cannot be reached.

	Name	Address	Home Phone	Cell Phone	Work Phone
Parent					
Parent					
Legal guardian if not parent					
Emergency Contact #1					
Emergency Contact #2					
Emergency Contact #3					
Emergency Contact #4					

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 _____

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**