

**OLENTANGY LOCAL SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION FORM
(PLEASE PRINT)**

STUDENT'S FIRST NAME – MIDDLE INITIAL – LAST NAME	() HOME PHONE NUMBER	GRADE
ADDRESS	CITY	ZIP
<i>The purpose of this form is 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.</i>		

EMERGENCY CONTACTS

	HOME PHONE	CELL PHONE
RESIDENTIAL PARENT OR GUARDIAN FIRST AND LAST NAME	WORK PHONE	CELL PHONE
RESIDENTIAL PARENT OR GUARDIAN FIRST AND LAST NAME	HOME PHONE	CELL PHONE
RESIDENTIAL PARENT OR GUARDIAN FIRST AND LAST NAME	WORK PHONE	CELL PHONE
OTHER PARENT, GUARDIAN OR RELATIVE'S FIRST NAME AND LAST NAME (RELATIONSHIP)	HOME PHONE	CELL PHONE
OTHER PARENT, GUARDIAN OR RELATIVE'S FIRST NAME AND LAST NAME (RELATIONSHIP)	WORK PHONE	CELL PHONE
IF PARENT OR GUARDIAN CANNOT BE REACHED – EMERGENCY CONTACT FIRST AND LAST NAME	HOME PHONE	CELL PHONE
IF PARENT OR GUARDIAN CANNOT BE REACHED – EMERGENCY CONTACT FIRST AND LAST NAME	WORK PHONE	CELL PHONE

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT		
<i>I hereby give consent for the following medical care providers and local hospitals to be called:</i>		
PHYSICIAN	()	OFFICE PHONE
DENTIST	()	OFFICE PHONE
MEDICAL SPECIALIST	()	OFFICE PHONE
LOCAL HOSPITAL	()	EMERGENCY ROOM PHONE
<i>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 designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to a hospital reasonably accessible.</i>		
<i>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.</i>		
<i>Facts concerning the child's medical history, including <u>allergies</u>, <u>medications being taken</u>, and any <u>physical impairments</u> to which a physician should be alerted are listed as follows:</i>		
DATE	SIGNATURE OF PARENT/GUARDIAN	
ADDRESS	CITY	ZIP

PART II: REFUSAL TO CONSENT		
<i>I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take the following action:</i>		
DATE	SIGNATURE OF PARENT/GUARDIAN	
ADDRESS	CITY	ZIP