Groveport Madison Local Schools
EMERGENCY MEDICAL AUTHORIZATION

Please Print

Student's Name ____ Male/Female____________ Grade _________
(Last) (First) (M.)

Street Address ____ Teacher/Team __________________________

City ____ School __________________________

(New Address? ___ Yes ___ No) Bus ____________

Name of Legal Guardian ____ Home Phone __________________________

With whom does the student reside? ______________________________ Cell Phone __________________________

Non-custodial parent may be contacted in the event I cannot be reached: ___Yes ___ No Birth Date __________________________

Name of non-custodial parent/guardian ____________________________ Phone Number __________________________

Mother's Name ______________________________ Home # ____________________ Work # _______________

Place of Employment __________________________ Cellular # __________________ Pager _______________

Father's Name ______________________________ Home # ____________________ Work # _______________

Place of Employment __________________________ Cellular # __________________ Pager # _______________

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

1. Name ____________________________________
   Relationship to student ______________________
   Address __________________________________
   Telephone ________________________________
   (Home) (Work)

2. Name ____________________________________
   Relationship to student ______________________
   Address __________________________________
   Telephone ________________________________
   (Home) (Work)

Known Allergies: ____

Current Medications: ____

Health Concerns: (diabetes, asthma, seizure, etc.) ____

Physical Impairments: ____

Date of last Tetanus booster: ____________________________

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EMERGENCY MEDICAL AUTHORIZATION
Part 1 or 2 Must Be Completed

Part 1 (Grant consent)

In the event reasonable attempts to contact me at ______________ (phone) or ______________ (phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by: Dr. ____________________ at ____________ (phone), or Dr. __________________ at _____________ (phone), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to _________________________________Hospital or any hospital reasonably accessible. 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 ___________________________

Part 2 (Refusal to grant consent) - Do not complete Part 2 if you completed Part 1

I do NOT give my consent for emergency medical treatment for 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 ___________________________

REQUIRED EACH YEAR BY STATE OF OHIO LAW: SECTION 3313.712, OHIO REVISED CODE

MUST BE COMPLETELY FILLED OUT