Groveport Madison Local Schools
Emergency Medical Authorization

Please Print

STUDENT INFORMATION

Name _____ Male/Female _____ Grade _____
Street Address _____ Teacher/Team _____ Bus _____
City _____ School _____
New Address? ____ Y ____ N Birth Date _____ Home Phone _____
Known Allergies _____
Current Medications _____
Health Concerns (diabetes, asthma, seizures, etc.) _____
Physical Impairments _____
Date of last Tetanus booster _____

PARENT/GUARDIAN INFORMATION

Mother's Name _____ Address _____
(Street) (City) (State)
Telephone _____Place of Employment_____
(Home) (Cell) (Work)

Father's Name _____ Address _____
(Street) (City) (State)
Telephone _____Place of Employment_____
(Home) (Cell) (Work)

Name of Student's Legal Guardian _____ Phone _____
With whom does the student reside? _____ Language Spoken at Home _____
Non-custodial parent may be contacted in the event I cannot be reached: _____Y _____ N
Name of non-custodial parent/guardian _____ Phone _____

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)

EMERGENCY MEDICAL AUTHORIZATION

Part 1 <u>or</u> Part 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