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