GALION CITY SCHOOL DISTRICT
Believe, Achieve, Succeed

Student Name: _____
Address: _____
DOB: _____ Grade: _____
School: _____

EMERGENCY MEDICAL AUTHORIZATION

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.

Residential Parent or Guardian

Name: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____
Relationship: _____

Name: _____ Cell Phone: _____
Home Phone: _____ Work Phone: _____
Relationship: _____

Relative or Childcare Provider: _____ Relationship: _____
Address: _____ Phone: _____

Part I – TO GRANT CONSENT:

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Local Hospital: _____ Emergency Room Phone:

In the event reasonable attempts to contact me have been unsuccessful, I herby 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 any hospital reasonably accessible.

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. In order for the cafeteria to make food substitutions, (including food allergies) a prescription must be provided annually. List below facts concerning the child's medical history including allergies, medications being taken, and any physical impairment which a physician should be alerted of

Allergies/Medical Issues **Treatment (including medications & dietary restrictions)**

_____
_____
_____
_____
_____
_____

Date: _____ **Signature of Parent/Guardian**: _____

PART II - 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:

_____

_____

_____

_____

_____

Date: _____ Signature of Parent/Guardian: _____

R.C.3313.72

SUPPLEMENTAL INFORMATION

(OPTIONAL)

Teacher/Homeroom: _____

Date of last Tetanus: _____

Student resides with (circle all that apply) Mother Father Step-parent Guardian Other

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Additional Contact Information for those who have authority to make decisions in an emergency situation involving this student.

Step-parent: _____ Home # _____ Work# _____ Cell# _____

Guardian: _____ Home # _____ Work# _____ Cell# _____

Alternate: _____ Home # _____ Work# _____ Cell# _____
(relative child care provider)