

MEDICAL INFORMATION

Student name: _____ Grade: _____

List any medication being taken _____

List any diseases or other serious illnesses, injuries, hospitalizations, or health conditions your child has had and give the year in which they occurred. Also include any items such as **asthma, allergies, bee sting reactions, and/or seizures**.

Note: If your child requires medication you must obtain a **Medical Authorization Form** from the school office. This form needs to be filled out and signed by the child's doctor and turned in to the office before school personnel can administer the medication. The medication needs to be in the original container you received from the pharmacy with the name and dosage written on the label.

Doctor: _____

Address: _____ **Phone:** _____

Dentist: _____

Address: _____ **Phone:** _____

Hospital: _____ **Phone:** _____

Mother: _____	Father: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

EMERGENCY MEDICAL/TRANSPORTATION AUTHORIZATION

TO PARENTS AND GUARDIANS: This is to authorize, or to decline to authorize, the provision of emergency treatment and/or transportation for children who become ill or injured while under school authority, **when parents or guardians cannot be reached for the purpose of giving consent for such treatment or transportation**. Such authority is necessary to overcome legal obstacles to the provision of treatment or transportation when all reasonable attempts to reach parents or guardians have failed. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. The authority granted by this form meets the specifications outlined by Section 3313.712 of the Ohio Revised Code.

PART I – TO GRANT CONSENT

Name of person who will assume financial responsibility for medical treatment: _____

Signed: _____ Date: _____

PART II – REFUSAL TO GIVE CONSENT

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: _____

Signed: _____ Date: _____