EMERGENCY MEDICAL AUTHORIZATION

BEXLEY CITY SCHOOL DISTRICT

____
Student Name

____
Address

____
Telephone

____
School Attended

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.

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me at _________________(phone number) or _________________________ (other parent/guardian) at _____________________ (phone number) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. ______________________ (preferred physician) or Dr. ____________________ (preferred dentist), 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 ________________________ (pre-ferred 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 the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ____

____

____

DATE ______________________ PARENT/GUARDIAN SIGNATURE ____

ADDRESS ____

****

****DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

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 no action or to: ____

____

____

DATE _________________ PARENT/GUARDIAN SIGNATURE ____

ADDRESS ____

BOTH SIDES OF THIS FORM MUST BE COMPLETED

ANNUAL HEALTH INFORMATION

BEXLEY CITY SCHOOL DISTRICT

Student Name ______________________________ Date ______________

Address ______________________________ Phone ______________

Grade __________ Homeroom Teacher ______________________________

Dear Parents: In addition to the State required Emergency Medical Authorization form which you have been asked to complete, we would appreciate your providing us with the information on this form. Experience has shown us that this additional data will be of great help in assuring your child of prompt medical care, arranged to your own wishes, should the need arise.

Father's Name ______________________ Mother's Name ______________________

______________________ Address (If different than student)

______________________ Address (If different than student)

______________________ Place of Employment

______________________ Place of Employment

(W) __________ (H) __________ Phone Numbers

(W) __________ (H) __________ Phone Numbers

PERSONS WHO WILL CARE FOR STUDENT IN CASE PARENT CANNOT BE REACHED:

1. ____
   (NAME) (ADDRESS) (TELEPHONE)

2. ____
   (NAME) (ADDRESS) (TELEPHONE)

List known health conditions or problems. (Please include allergies, recent illnesses, injuries, and any restrictions associated with health concerns.)

____

____

Name of Physician ______________________ Date of Last Examination __________

Is student taking medication regularly? __________ If so, what? ______________________

Immunizations or boosters received during past year? ______________________

Does student wear glasses? __________ Contact Lenses?__________

Date of last vision examination: __________ Eye Specialist: ______________________

Brothers and Sisters:

Name ______________________ Grade ______ Name ______________________ Grade ______

Name ______________________ Grade ______ Name ______________________ Grade ______

Parent/Guardian Signature ______________________________ Date ______________

<u>BOTH SIDES OF THIS FORM MUST BE COMPLETED</u>