# EMERGENCY MEDICAL AUTHORIZATION (O.R.C. 3313.712)
## PARMA CITY SCHOOL DISTRICT

Student's Name _____ Soc. Sec. No. _____
Last First Initial

Address _____ Phone _____

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.

**RESIDENTIAL PARENT or GUARDIAN**

Mother's Name _____ Daytime Phone _____ Cell Phone _____

Father's Name _____ Daytime Phone _____ Cell Phone _____

Other's Name _____ Daytime Phone _____ Cell Phone _____

Name of Relative or Childcare Provider _____ Relationship _____

Address _____ Daytime Phone _____ Cell Phone _____

## PART I or PART II (MUST BE COMPLETED)

## 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 _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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.

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

_____

_____

_____

Date _____ Signature of Parent/Guardian _____

Address _____

## PART II - REFUSAL TO CONSENT

***I do NOT give my consent for emergency 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 _____

Address _____

**STUDENT ACCIDENT INSURANCE** (Place your initials on the line next to your choice)

_____ I DO want student accident insurance. I understand that placing my initials here does NOT enroll my child. ***I must complete a separate insurance application form and submit it with payment to the insurance company.***

_____ I do NOT want student accident insurance.