Student Name:_____ Homeroom Teacher: _____
Last First

WICKLIFFE CITY SCHOOLS
Emergency Medical Authorization Form

Student Name: _____ Homeroom Teacher:_____
Last First Grade:_____ Room: _____Student ID #_____

Address:_____ Date of Birth: _____

City, State, Zip: _____ Home Phone: _____

Has this address changed from last year? YES NO Has home phone changed from last year? YES NO

Purpose- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached. In addition, limited health information necessary for personal safety and education interest may be shared with selected school staff members in order to maintain a safe school environment

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☐ **RESIDENTIAL PARENT/GUARDIAN:**
Mother's Name: _____

Home Address:_____ Home Phone:_____

Email Address:*_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Work Address: _____

☐ **RESIDENTIAL PARENT/GUARDIAN:**
Father's Name: _____

Home Address:_____ Home Phone:_____

Email Address:*_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Work Address: _____

ADDITIONAL EMERGENCY CONTACTS THE STUDENT MAY BE RELEASED TO:

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

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*The district cannot assume responsibility for the confidentiality of education information disclosed through electronic correspondence.

Student Name:_____ Homeroom Teacher: _____
Last First

PART I OR 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:

Physician: _____ Phone:_____

Dentist: _____ Phone:_____

Medical Specialist: _____ Phone:_____

Local Hospital: _____ Phone:_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by the 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 options of two other licensed physicians or dentists, concur 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 impairment which a physician should be alerted:**

_____

_____

_____

_____ _____
Signature of Parent/Guardian Date

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 treatment, I wish the school authorities take the following action:

_____
_____
_____
_____
_____
_____

_____ _____
Signature of Parent/Guardian (Do not sign here if you signed Part I.) Date

c: Clinic
Student File
Transportation Department

Revised Code §3313.712
Revised: July 1, 2011