

# Springboro Community City Schools

## EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached and to authorize the release of medical information to school officials/employees who have responsibility for the student while the student is at school or school events and/or is being transported by the schools.

### Student Information

Student Name: \_\_\_\_\_ Building: \_\_\_\_\_ Grade \_\_\_\_\_ Rm # \_\_\_\_\_ Bus #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ @ \_\_\_\_\_  
Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ @ \_\_\_\_\_  
Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_ @ \_\_\_\_\_

**Is there a legal custody order that applies to this child?** (Please circle)    Yes    or    No

If yes, please give details: \_\_\_\_\_

### Name of Relative or Child Care Provider

Name: \_\_\_\_\_ Phone# \_\_\_\_\_ Relationship \_\_\_\_\_  
Address: \_\_\_\_\_

### Emergency Contacts (if parent/guardian cannot be reached)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### Emergency Care Information

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Allergies and/or Specific Health Considerations: \_\_\_\_\_

## CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 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 performance of such surgery. In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all school personnel that interact with my child.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

Student Signature (if 18 yrs of age or older): \_\_\_\_\_ Date \_\_\_\_\_

## 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 schools authorities to take no action or to: (please explain) \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_