

# Boardman Local Schools Emergency Medical Authorization

**PART I OR PART II MUST BE COMPLETED**

**PART I (CONSENT FOR TREATMENT)**

Student Last Name \_\_\_\_\_ First \_\_\_\_\_ School \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Homeroom \_\_\_\_\_

I HEREBY GIVE MY CONSENT for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_  
 (Preferred Physician/Phone Number) \_\_\_\_\_  
 or Dr. \_\_\_\_\_, or, in the event  
 (Preferred Dentist/Phone Number) \_\_\_\_\_  
 the DESIGNATED preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to \_\_\_\_\_ hospital or any hospital reasonably accessible.

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
 Mother's Work Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_  
 Mother's Cell Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

**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.

IN the event reasonable attempts have been unsuccessful to contact a parent at the above numbers you have my permission to contact anyone listed below:

Name	Phone	Relation

**FACTS CONCERNING THE CHILD'S HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS SUCH AS HEART CONDITION, DIABETES, EPILEPSY, ETC., TO WHICH A PHYSICIAN AND SCHOOL STAFF SHOULD BE ALERTED.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent Guardian Giving CONSENT \_\_\_\_\_

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

**PART II (REFUSAL OF CONSENT FOR TREATMENT)**

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IMPORTANT NOTICE**

1. List at least 2 contact persons (other than parents)
  2. PLEASE update information - changes in name, address, phone number, etc.
  3. List medical conditions - allergies, asthma, diabetes, epilepsy, etc.
  4. List medications. Include inhalers, pills and liquids.
- The STATE OF OHIO **requires** the Medical Emergency Authorization form to be completed **and on file** in the school ANNUALLY.

This enables us to assist your child in times of illness and/or injury. **Thank You**

Date \_\_\_\_\_ Signature of Parent Guardian Giving NO CONSENT \_\_\_\_\_