EMERGENCY MEDICAL AUTHORIZATION

DIRECTIONS: Please complete the following information and print any changes since last school year. Return this form to the building principal.

_____ **ID#**_____
Please Print Student's Legal Name Last First Middle Initial **For Office Use Only**

_____ _____ _____ ☐ Franklin Co. ☐ Delaware Co.
Address City Zip Code+4

_____ _____ _____ _____ ☐ Male ☐ Female
Home Telephone Date of Birth Grade Social Security Number

SCHOOL	TEACHER	ROOM	BUS

_____ _____ _____ _____
Legal Guardian (1) Daytime Phone Evening Phone Pager

_____ _____ _____
Workplace Cell Phone E-mail Address

_____ _____ _____ _____
Legal Guardian (2) Daytime Phone Evening Phone Pager

_____ _____ _____
Workplace Cell Phone E-mail Address

Verification of legal custody must be presented to school office

Marital status of student's natural/legal parents: ☐ Married ☐ Divorced ☐ Other_____

Legal custody: ☐ Mother ☐ Father ☐ Joint ☐ Other_____

If student resides with a non-parent, what is the school district where the natural/legal parent(s) resides?_____

The Westerville Schools cannot assume responsibility for treatment of an ill or injured child beyond the administration of first aid.

#1_____ _____
Emergency contact person other than parent ☐ Neighbor ☐ Friend ☐ Relative Daytime Phone

#2_____ _____
Emergency contact person other than parent ☐ Neighbor ☐ Friend ☐ Relative Daytime Phone

_____ _____ _____
Physicians's Name Phone Mother's Maiden Name

In case of early dismissal, my child should go home: ☐ Yes ☐ No If no, where should child go?_____

WESTERVILLE CITY SCHOOLS Emergency Medical Authorization – Section 3313.712 Ohio Revised Code

DIRECTIONS: Please complete the following information and sign below:

Purpose – to enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.
Facts concerning the child's medical history – including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

☐ Medical issues are:_____

☐ No medical issues.

PART I OR II MUST BE COMPLETED (All blanks must be completed and card must be signed)

PART I – TO GRANT CONSENT

If reasonable attempts to contact me at_____OR_____ _____have been unsuccessful, I hereby
Other Parent Phone
give my consent for (1) the administration of any treatment deemed necessary by:

Dr._____ _____ Dr._____ _____
(Preferred Physician) Phone (Preferred Dentist) Phone
In the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) transfer of the child to

_____, or any hospital reasonably accessible.
(Preferred Hospital)
This authorization does not cover major surgery unless medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

_____ _____
Signature of Parent 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 emergency treatment, I wish the school authorities to take no action, OR
to:_____

_____ _____
Signature of Parent Date