

EMERGENCY MEDICAL AUTHORIZATION

School District _____	Student Name _____	Grade _____
RESIDENTIAL PARENT OR GUARDIAN _____		Street Address _____
Mothers's Name _____	(Daytime Phone) _____	City _____
Father's Name _____	(Daytime Phone) _____	Zip _____
Other's Name _____	(Daytime Phone) _____	Telephone _____
Name of Relative or Childcare Provider: _____	E-Mail address: _____	
(Name) _____	(Address) _____	(Phone) _____
		(Relationship) _____

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.

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:

Doctor _____	Phone Number _____
Dentist _____	Phone Number _____
Medical Specialist _____	Phone Number _____
Local Hospital _____	Emergency Room Phone _____

IN THE EVENT RESONABLE 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 PHYSICAN 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 physicans 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, medications being taken, and any physical impairments to which a physician should be alerted: _____

(Date) _____	(Signature of Parent/Guardian) _____	
(Address - street) _____	(City) _____	(Zip) _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 the following action:

(Date) _____	(Signature of Parent/Guardian) _____
(Address - street) _____	(City) _____
(Zip) _____	

SECTION 3313.712, OHIO REVISED CODE
(Pursuant to H.B. 811 and H.B. 639)
(Effective 6-11-92)

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local or joint vocational school district to which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his child.

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows: (See reverse side)

Consent for Administration of Over the Counter Medications

You have been asked to send any medications to camp that your child takes on a regular basis. From past experience, we have found that there are many "unanticipated" needs for over-the-counter medications, such as headaches, muscle aches, colds, minor sore throats, and ailments. We do have medications available for these needs. As our band grows, the list of medications and kids we are responsible for has greatly increased. For the safety and health of your children, we are asking for written consent before administering any medications. There will be a record kept of what medications are given so that appropriate doses are given. You will always be called in the event of any serious illness or injury, fever, or at any time your child or any of the camp staff feels that you should be called. Please mark with an "X" any of the following medications that you give permission for your child to receive if needed.

_____ Ibuprofen (Motrin, Advil) for headaches, sore muscles, sore throat

_____ Sudafed for colds or congestion

_____ Benadryl for allergies, itching

_____ Tylenol for headache, sore muscles sore throat

_____ Pectin throat lozenges for sore throat (usually from yelling!)

_____ Pepto-Bismol for nausea, diarrhea, upset stomach

_____ Dextromethorphan (Robitussin DM) for cough

I give consent for my child, _____ to
receive the above checked over the counter medications as needed.