

# Gahanna Jefferson Public Schools

160 South Hamilton Road • Gahanna, Ohio 43230 • (614) 471-7065

## EMERGENCY MEDICAL AUTHORIZATION Required by Section 3313.712 of the Ohio Revised Code

Nickname\_\_\_\_\_

School\_\_\_\_\_

Student Name\_\_\_\_\_

(First) (M.I.) (Last)

Grade \_\_\_\_\_

D.O.B. \_\_\_\_\_

Teacher\_\_\_\_\_

Address \_\_\_\_\_

City\_\_\_\_\_ Zip\_\_\_\_\_

Home phone\_\_\_\_\_

### **EMERGENCY CONTACTS**

#### **Call First: (Residential Parent or Legal Guardian)**

Name\_\_\_\_\_

Relationship to student:\_\_\_\_\_

Address:\_\_\_\_\_

Home Phone:\_\_\_\_\_

\_\_\_\_\_

Work/Daytime Phone:\_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_

#### **Call Second:**

Name\_\_\_\_\_

Relationship to student:\_\_\_\_\_

Address:\_\_\_\_\_

Home Phone:\_\_\_\_\_

\_\_\_\_\_

Work/Daytime Phone:\_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_

**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.**

#### **Call Third:**

Name\_\_\_\_\_

Relationship to student:\_\_\_\_\_

Address:\_\_\_\_\_

Home Phone:\_\_\_\_\_

\_\_\_\_\_

Work/Daytime Phone:\_\_\_\_\_

Cell Phone/Pager: \_\_\_\_\_

**OVER→**

Please list any other exclusions of service (i.e. no blood or blood products, no advanced life support, etc.):

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Allergies: \_\_\_\_\_ type of reaction: \_\_\_\_\_ treatment: \_\_\_\_\_

Current medications- include dose and frequency (at home & school)

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Physical/Medical conditions (examples – asthma, diabetes, seizures, developmental disorders):

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## Please complete and sign EITHER PART 1 OR PART 2

### **PART I – TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

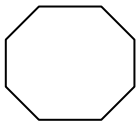
Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_  
Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable 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 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 opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Address \_\_\_\_\_



**STOP HERE if you have completed and signed Part I**

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### **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:

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

Address \_\_\_\_\_