

STUDENT NAME \_\_\_\_\_  
(Please print) First Middle Last

**Eaton Community Schools**  
**EMERGENCY MEDICAL AUTHORIZATION FORM**  
(Ohio Revised Code 3313.712)

HAS YOUR ADDRESS OR  
PHONE INFORMATION  
CHANGED FROM THE  
PREVIOUS YEAR?  
YES  NO

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
School Building \_\_\_\_\_ Address \_\_\_\_\_  
Grade Level \_\_\_\_\_ Bus No. \_\_\_\_\_ Teacher (Gr. K-6) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**Purpose:** To enable parents/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. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel, including student nurses, and other school personnel.

**Complete section for who student lives with:**

Student lives with (please circle) Father & Mother Mother only Father only Shared Parenting Other (explain) \_\_\_\_\_

**Mother/Guardian:**

Name: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Business Phone: \_\_\_\_\_

**Step-Father (if applicable):** \_\_\_\_\_

Place of Employment: \_\_\_\_\_

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

**Relative or Child Care Provider** \_\_\_\_\_

Work: \_\_\_\_\_

**Father/Guardian:**

Name: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Business Phone: \_\_\_\_\_

**Step-Mother (if applicable):** \_\_\_\_\_

Place of Employment: \_\_\_\_\_

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

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

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

Is the student a dependent of a person currently ACTIVE in the Military or National Guard? Y or N If yes, please list branch: \_\_\_\_\_

List below the names of all brothers and sisters at home or in school. Please list age and grade level.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List 3 names of persons to be contacted in the event of an emergency - OTHER THAN RESIDENTIAL PARENT  
(3 local contacts in order of priority)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell/Home (circle) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell/Home (circle) \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cell/Home (circle) \_\_\_\_\_

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child at school

Medical Information (Past/Current): \_\_\_\_\_

All Medications (Home/School): \_\_\_\_\_

Allergies (Medical/Food/Other): \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**PART I: TO GRANT CONSENT**

A. I 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.

B. I authorize the Eaton Community School District to release any information which I have provided this school district concerning any medical history, including information regarding allergies, medications, physical condition, etc. of the student named above, to any employee of the school district and/or volunteer providing medical service to the school district who has responsibility for such student while the student is at school, participating in a school sponsored function, or is being transported by the school.

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

**PART II: REFUSAL TO GRANT 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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