STUDENT NAME _____
(*Please print*) First Middle Last

HAS YOUR ADDRESS OR PHONE INFORMATION CHANGED FROM THE PREVIOUS YEAR?
Yes _____ No _____

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

Date of Birth _____ Home Phone _____
School Building _____ Home 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.

PARENT INFORMATION: Student lives with (please circle)

Father & Mother Mother only Father only Shared Parenting Other (explain)_____

Mother/Guardian:

Name: _____
Address: _____
Home/Cell Phone: _____
Email address:_____
Place of Employment: _____
Business Phone: _____
Step-Father (if applicable): _____
Place of Employment: _____
Phone: _____

Father/Guardian:

Name: _____
Address: _____
Home/Cell Phone: _____
Email address:_____
Place of Employment: _____
Business Phone: _____
Step-Mother (if applicable): _____
Place of Employment: _____
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:_____

Are you currently homeless, doubled-up (living in someone else's home for **economic** reasons), or an unaccompanied youth living in someone else's care that is not a custodial adult? _____ **Yes** or _____ **No**

Are you living in any of the following? Please mark ____ Transitional Housing, including any residence of the HIT Foundation; _____ shelter, trailer or hotel

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

REV 1/2019