Cincinnati Public Schools

Emergency Medical Authorization Form

Please fill out this form and return it to your child's school.

Student's Name: ______________________________ ID #: _________ Homeroom: ______ Birth Date: _________

School: ____ Grade: _______ Year: _________

Student's Address: ____ Apt.: ________ Phone: (   ) ____________

City: ____________________________ State: _________ Zip: _______________

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.

Residential Parent or Guardian

Mother's Name:____ Daytime Phone: (   ) ____________

Father's Name: ____ Daytime Phone: (   ) ____________

Other's Name: ____ Daytime Phone: (   ) ____________

Name of Relative or Child-care Provider: ____

Relationship: ____ Daytime Phone: (   ) ____________

Address: ____ Zip: __________

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:

Physician: ____ 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 doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my 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.

Facts concerning my 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: ____ Zip: __________

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 to take the following action:

____

____

Date: _________ Signature of Parent/Guardian: ____

Address: ____ Zip: __________

Rev: 6/2013