Conneaut Area City Schools

BOARD OFFICES, 230 Gateway Avenue, Conneaut OH 44030 – 440-593-7200

EMERGENCY MEDICAL AUTHORIZATION 18/19 School Year

IMPORTANT PLEASE READ

This form (front & back) must be completed

and returned to school the next school day.

Failure to do so may result in your child being excluded from attending school.

You must notify the school immediately when your address, phone or other contact information has been changed.

Student Name

Student's Address

Student's Home Phone Number

School Building

Homeroom Teacher

Grade Locker No. Bus No. Birth Date

Parent/Guardian Information

Parent Status:	☐Married ☐Divorced ☐Legally Separated ☐ Separated ☐Never Married ☐Deceased: ☐Both ☐ Mother ☐ Father
Student lives with: Please check ALL that apply	☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other:_____
Custody of Student: Please check ALL that apply	☐Mother ☐Father ☐Stepmother ☐Stepfather ☐Other:_____

	Parent/Guardian Contact 1	Parent/Guardian Contact 2
Name and Relationship		
Address if different than student		
Primary Contact Phone		
Mobile Phone		
Email Address		
Employer		
Work Phone		

If your child should become ill or hurt while at school and we are unable to reach you, we must have the name or names of SOMEONE ELSE LOCAL TO CALL FOR ASSISTANCE. Please list below: DESIGNATED PERSON(S)

Name _____ Relationship _____

Address _____ Phone: _____ Cell_____

Name _____ Relationship _____

Address _____ Phone: _____ Cell_____

BROTHERS/SISTERS IN THE DISTRICT

Name & Grade	Name & Grade	Name & Grade

The purpose of this Emergency Medical Authorization is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill and/or injured while under school authority, when parents/guardians cannot be reached.

OVER ⇨

EMERGENCY MEDICAL AUTHORIZATION

PART I To Grant Consent

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

Physician _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me or - **MY DESIGNATED PERSON/S** have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors or by another licensed physician or dentist in the event the designated preferred practitioner is not available 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 performance of such surgery.

List and explain facts concerning the child's medical history including: allergies, current medications, and any illness or physical impairment to which a physician should be alerted.

_____

_____

_____ _____

Date Signature and relationship to student

Address _____

_____

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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:

_____

_____

AND In a life-threatening emergency, Ashtabula County EMIS protocol dictates that the patient be taken to the nearest facility.

_____ _____

Date Signature and relationship to student

Address _____

_____

REV: 2015