

YOUNGSTOWN CHRISTIAN SCHOOL EMERGENCY MEDICAL AUTHORIZATION

School Year 2015-2016

VALLEY CHRISTIAN SCHOOL School Year 2015-2016
4401 SOUTHERN BLVD. YOUNGSTOWN, OHIO 44512 330-788-8088

EMERGENCY MEDICAL AUTHORIZATION

The STATE OF OHIO requires the Medical Emergency Authorization form to be completed and on file in the school **ANNUALLY**.

STUDENT LEGAL NAME _____ GRADE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ GENDER: M F (CIRCLE ONE) _____ STUDENT CELL PHONE _____

Parents/Guardians <small>(Custody papers Must be on file In building)</small>	Who has custody: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Other	The student is living with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Mother/Stepfather <input type="checkbox"/> Father/Stepmother <input type="checkbox"/> Other
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***PLEASE list in ORDER Who Should Be Contacted In Case of a Problem or Emergency:** (Adults who *have permission* to pick up your child)

Residential Mother/Stepmother: _____

Home _____ Work _____ Cell _____

Residential Father/Stepfather: _____

Home _____ Work _____ Cell _____

Name/Relationship: _____

Home _____ Work _____ Cell _____

Name/Relationship: _____

Home _____ Work _____ Cell _____

Name/Relationship: _____

Home _____ Work _____ Cell _____

Name/Relationship: _____

Home _____ Work _____ Cell _____

PURPOSE: TO ENABLE PARENTS AND GUARDIANS TO AUTHORIZE THE PROVISION OF EMERGENCY TREATMENT OF CHILDREN WHO BECOME ILL OR INJURED WHILE UNDER SCHOOL AUTHORITY, WHEN PARENTS OR GUARDIANS CANNOT BE REACHED.

PART I (consent) OR PART II (refusal) MUST BE COMPLETED:

Preferred Physician _____ Phone Number _____

Preferred Dentist _____ Phone Number _____

Medical Specialist _____ Phone Number _____

Local Hospital _____ Phone Number _____

PART I (CONSENT FOR TREATMENT)

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 each surgery.

Please list all medications and dose the child takes on a regular basis (please include Inhalers, pills and liquids)

Signature of parent or guardian GIVING CONSENT _____ Date _____

PART II - REFUSAL TO CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I)
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 NO ACTION OR TO:

Signature of parent or guardian REFUSING CONSENT _____ Date _____