Springboro Community City Schools
EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached and to authorize the release of medical information to school officials/employees who have responsibility for the student while the student is at school or school events and/or is being transported by the schools.

Student Information

Student Name:_____ Building:_____ Grade_____ Rm #_____ Bus #:_____

Address:_____ Home Phone:_____ Date of Birth _____

Mother's Name:_____ Daytime Phone:_____ Cell Phone: _____

E-Mail:_____@_____

Father's Name:_____ Daytime Phone:_____ Cell Phone: _____

E-Mail:_____@_____

Other's Name:_____ Daytime Phone:_____ Cell Phone: _____

Is there a legal custody order that applies to this child? (Please circle) Yes or No

If yes, please give details:_____

Emergency Contacts (will be called in the order given if parent/guardian **CAN NOT** be reached)

1. Name:_____Relationship:_____Phone:_____Cell:_____
2. Name:_____Relationship:_____Phone:_____Cell:_____
3. Name:_____Relationship:_____Phone:_____Cell:_____
4. Name:_____Relationship:_____Phone:_____Cell:_____

Emergency Care Information

Preferred Physician:_____Phone:_____Fax:_____

Preferred Dentist:_____Phone:_____Fax:_____

Preferred Hospital:_____Phone:_____Fax:_____

Allergies and/or Specific Health Considerations:_____

_____

CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 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 performance of such surgery. In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all school personnel that interact with my child.

Parent/Guardian Signature:_____***Date***_____

Student Signature (if 18 yrs of age or older):_____Date_____

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 schools authorities to take no action or to: (please explain)_____

_____

Parent/Guardian Signature:_____***Date***_____

Copies: Building Office School Nurse Teacher Transportation

Revised 1/11/07