PICKERINGTON LOCAL SCHOOL DISTRICT
777 Long Road, Pickerington, Ohio 43147
Phone: 614-833-2110 Fax: 614-833-2143
www.pickerington.k12.oh.us

EMERGENCY MEDICAL AUTHORIZATION

School: _____

Student Name: _____ Birth Date: _____ Grade: _____ Homeroom: _____

Address: _____ Telephone: _____

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 Information:	Home Phone	Work Phone	Cell Phone	E-mail Address
Mother's Name:				
Father's Name:				
Alternate Contact Name:				
Address:		**Relationship to child:**		

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT
I hereby give consent for the following medial 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.
- Pertinent health information will be shared with appropriate school staff only on a need-to-know basis.
- Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: _____

_____

_____ _____

Date *Signature of Parent/Guardian*

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 with the school authorities to take the following action: _____

_____

_____ _____

Date *Signature of Parent/Guardian*