

**EMERGENCY MEDICAL AUTHORIZATION
SEC. 3313.712 OHIO REVISED CODE**

School District

Student Name

Address

Telephone

School Attended

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.

**PART I OR II MUST BE COMPLETED
PART I TO GRANT CONSENT**

In the event reasonable attempts to contact me at _____ (phone number)
or _____ (other parent/guardian) at _____ (phone number)
have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed
necessary by Dr. _____ (preferred physician) or Dr. _____
(preferred dentist), or, in the event the designated preferred practitioner is not available, by another
licensed physician or dentist; or (2) the transfer of the child to _____ (preferred
hospital) or any hospital reasonably accessible.

(CONTINUED) - - PARENT/GUARDIAN SIGN ON BACK

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 the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted. _____

Date

Signature of Parent or Guardian

Address

**DO NOT COMPLETE PART II IF YOU COMPLETED PART I
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 no action or to: _____

Date

Signature of Parent or Guardian

Address