MARYSVILLE
Exempted Village School District

Board of Education
1000 Edgewood Dr.
Marysville, OH 43040
Office 937-578-6100
Fax 937-578-6113

EMERGENCY MEDICAL AUTHORIZATION FORM

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.

First Name: _____ **MI:** _____ **Last Name:** _____

Grade: _____ **Date of Birth:** _____ **Phone Number:** ( ) _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Student Email Address: _____ **Guardian Email Address:** _____

People to call when a student is ill, or in case of emergency: (LIST AREA CODE IF DIFFERENT THAN 937)

	Name	Relationship	Primary phone #	Secondary phone #	Employer
Parent/Guardian:					
Parent/Guardian:					
Other:					
Other:					
Other:					

Child Lives With: (Circle One) Mother/Father Mother Only Father Only Guardian Mother/Stepfather Father/Stepmother Grandparents Foster Parents Self Supporting

Guardianship: (Circle One) Mother/Father Mother Only Father Only Guardian Grandparents Foster Parents Self Supporting

CUSTODY PAPERWORK ON FILE (IF APPLICABLE) _____ (Yes or No) Shared Parenting _____ (Yes or No)

Shared Parent (non-residential parent) / Non Custodial Parent Address

Name: _____ Phone: _____ Email: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

EMERGENCY MEDICAL AUTHORIZATION You MUST complete PART I OR PART II

Part I– TO GRANT CONSENT

I hereby give consent for the following medical care providers or hospitals to be called:

Doctor: _____ Phone: ( ) _____

Dentist: _____ Phone: ( ) _____

Allergies, Medical Conditions OR Medications: **YES** ☐ **NO** ☐ **If YES, turn form over to explain in detail**

The local emergency squads will transport to Marysville Hospital ONLY **E.R. Phone (937) 578-2402**

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 the 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.

Date: _____ **Signature of Parent or Guardian:** _____

OR

Part II– REFUSAL TO CONSENT

I do NOT give my consent for the 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: _____

_____

Date: _____ **Signature of Parent or Guardian:** _____

PLEASE TURN FORM OVER TO FILL OUT THE REQUIRED HEALTH INFORMATION

STUDENT'S NAME _____

Health Conditions

- ☐ Abnormal Spinal Curvature
- ☐ Activity limitation/restriction
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Asthma or Wheezing. *Medication/emergency treatment
- ☐ Allergy*: type _____

_____

_____

*Medication/Emergency treatment - note below

- ☐ Behavior problems
- ☐ Birth or Congenital malformations
- ☐ Cancer*: type _____
- ☐ Chicken pox: date
- ☐ Chronic bowel problems
- ☐ Cystic Fibrosis
- ☐ Depression
- ☐ Dermatitis/Eczema
- ☐ Diabetes*
- ☐ Ear infections, chronic: last:
- ☐ Tubes: yes/no date:
- ☐ Emotional problems
- ☐ Epilepsy/Seizures: type
- ☐ Headaches, frequent
- ☐ Hearing disorder
- ☐ Heart Disease/Condition: type
- ☐ Hepatitis: type
- ☐ Kidney disease: type
- ☐ Measles, mumps, and/or Rubella: type and date
- ☐ Meningitis or Encephalitis: type and date
- ☐ Muscular/skeletal disorder
- ☐ Nervous Tic
- ☐ Nose Bleeds, frequent
- ☐ Physical Handicap
- ☐ Respiratory infections, frequentRheumatic Fever
- ☐ Serious blows to head (concussions)
- ☐ Sickle cell disease
- ☐ Sinus issues
- ☐ Speech issue—explain
- ☐ Sore throats, frequent
- ☐ Stool soiling
- ☐ Substance abuse
- ☐ Suicide risk
- ☐ Urinary tract problems
- ☐ Wears glasses/contact/vision condition last exam:
- ☐ Weight concerns
- ☐ Wetting (day/night)
- ☐ Other _____

_____

Explain: _____

If any condition above with * denoted, contact the school nurse or http://www.marysville.k12.oh.us/site/schools/ for the required medication and/or physician authorization forms.

Does this child have any condition that could be life threatening? CIRCLE ONE: YES OR NO

If YES, please explain: _____

_____

Medications

List all prescribed medications taken on daily basis at home _____

List all prescribed medications that will be taken daily at school _____

Please refer to the student handbook or http://www.marysville.k12.oh.us/site/District/health/content.asp?topic=medication for rules regarding medication at school.

Please note that a new medication consent form must be completed every year (even if medication has not changed).

Parent (s) Names: _____

Primary Phone: _____ Secondary Phone: _____ Work Phone: _____

I understand that this health information may be shared with school staff, on a need to know basis, maintaining student confidentiality and complying with privacy standards.

Parent/Guardian Signature: _____

FOR OFFICE USE ONLY Health HX.reviewed by _____ Date _____

Comments _____

_____