WEST CLERMONT
SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: Enables parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. This Emergency Medical Authorization, required by O.R.C. 3313.712, must be on file for each student

PLEASE PRINT AND RETURN TO SCHOOL WITHIN 7 DAYS.

Your Email Address _____

Please Print

Student's Name _____ School _____ Grade _____
Student's Address _____
Date of Birth _____ Student ID _____ Teacher _____

Note: Listing individuals below allows your student to be released to those individuals (must be age 18 or over).

Parent/Guardian's Name _____ Relation to Student _____
Home Phone _____ Cell _____ Work _____

Parent/Guardian's Name _____ Relation to Student _____
Home Phone _____ Cell _____ Work _____

List in order person(s) who may be notified and to whom your child may be released if the school cannot reach you:

Name	Relationship	Home Phone	Cell Phone	Work Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Facts concerning the child's medical history including allergies, medications and any physical impairment to which a physician should be alerted _____

Doctor to be called _____ Phone _____
Dentist to be called _____ Phone _____
Preferred Local Hospital _____

Part 1 – TO GRANT CONSENT

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 preferrred hospital 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.

Date _____ Signature of parent/guardian _____

Part 2 – 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 the following action. _____

Date _____ Signature of parent/guardian _____