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educational service center
of Central Ohio

Emergency Medical Authorization

Student Name: _____

Address: _____ Phone Number: _____

_____

School: _____ Grade: _____

The following is required by Section 3313.712 of the Ohio Revised Code.

Purpose – To enable parents to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Part I or Part 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 the event the designated preferred practitioner is not available, by other licensed physician or dentist; (2) the transfer of the child to _____ (Preferred Hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

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

_____

_____

_____ _____
Parent or Guardian's Signature Date

Do Not Complete Part II if you have completed Part I.

Part II (Refusal to Consent)

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school to take no action or to:

_____

_____

_____ _____
Parent or Guardian's Signature Date