Grade: _____

Our Lady of Mount Carmel Parish School
2018-2019
EMERGENCY MEDICAL AUTHORIZATION

Health Conditions: (please check)

_____Asthma _____Bee Sting Allergy _____Diabetes _____Seizures

___Food/Medication Allergy (please list)_____

___Other (please explain)_____

Does this child have any life-threatening medical condition that would necessitate a school staff member administrating medication, injection or other treatment to prevent death?_____YES _____NO. If yes, please explain: _____

_____

Our Lady of Mount Carmel School staff is committed to meeting the needs of all students, in so far as possible. There are some conditions, however, for which the school cannot provide the necessary resources.

Name of Child	Parent 1/Guardian Name	Parent 2/Guardian Name
Street Address	Employer's Address	Employer's Address
City, State, Zip	City, State, Zip	City State, Zip
Telephone Number	Employer's Telephone Number	Employer's Telephone Number

List any other telephone number or cell phone number where parents or guardians can be reached while child is at school:

Parent 1/Guardian: (cell phone)_____ (other)_____
Parent 2/Guardian: (cell phone)_____ (other)_____

PLEASE LIST WHICH PARENT SHOULD BE CALLED FIRST: _____.

If the parent/guardian cannot be contacted in the event of illness or an emergency, please list *another adult who will authorize medical care, who are available during school hours and be available to pick-up your child within 20 minutes*.

Name	Name	Name
Street Address	Street Address	Street Address
City, State, Zip	City, State, Zip	City State, Zip
Telephone Number Employer Number Cell Phone	Telephone Number Employer Number Cell Phone	Telephone Number Employer Number Cell Phone
Relationship to Child	Relationship to Child	Relationship to Child

PLEASE COMPLETE SIDE TWO
EMERGENCY MEDICAL AUTHORIZATION

The following is required by Section 3313.712 of the Ohio revised Code
All blanks must be completed.

Either Part 1 or Part 2 must be completed. **DO NOT COMPLETE BOTH.**

PART 1. To GRANT Consent

In the event reasonable attempts to contact me at _____ or other
phone number
parent/guardian at _____, or the above individuals have been
phone number
unsuccessful, I give my consent for:

1. The administration of any treatment deemed necessary by or in the event the designated practitioner is not available, by another licensed physician or dentist:

Name of Physician _____ **Phone Number** _____

Name of Dentist _____ **Phone Number** _____

2. The transfer of the child to (Name of Hospital)_____. If no hospital is listed, child will be transported to a hospital within reasonable access.

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 before surgery is performed.

LIST ANY FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED _____

_____

Parent/guardian's signature _____ **Date** _____

DO NOT COMPLETE IF YOU HAVE COMPLETED PART 1.

Part 2. REFUSAL to Grant 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:

_____

_____

Parent/guardian's signature _____ **Date** _____