EMERGENCY MEDICAL AUTHORIZATION

Marion City School District *Section 3313.712 Ohio Revised Code*

Student Name _____ Telephone _____

Address _____ D.O.B. _____

School Attending _____

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 Part II MUST BE COMPLETED

PART I - TO GRANT CONSENT

In the event that reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) 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, and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

(see reverse side)

Form MCS - 47

EMERGENCY MEDICAL AUTHORIZATION

Marion City School District *Section 3313.712 Ohio Revised Code*

Student Name _____ Telephone _____

Address _____ D.O.B. _____

School Attending _____

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 Part II MUST BE COMPLETED

PART I - TO GRANT CONSENT

In the event that reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) have been unsuccessful, I hereby give my consent for (1) 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, and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

(see reverse side)

Form MCS - 47

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 the surgery is performed.

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

_____

_____

_____

Date_____ Signature of Parent or Guardian _____

Address _____

Do Not Complete Part II If You Have 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 _____

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 the surgery is performed.

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

_____

_____

_____

Date_____ Signature of Parent or Guardian _____

Address _____

Do Not Complete Part II If You Have 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 _____