

EMERGENCY CONTACT INFORMATION

O.R.C. 3313.712

Student Name _____ Grade _____ Classroom Teacher _____

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. Please list contacts in order of preference.

Name	Phone No. & Type of Phone	Relationship to Student	Address
1.			
2.			
3.			
4.			
5.			
6.			

PART I or II MUST BE COMPLETED

Part I – To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____
Dentist _____ Phone _____
Medical Specialist _____ Phone _____
Local Hospital _____ Phone _____

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 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.

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.

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

Date _____

Signature of Parent/Guardian

Part II – Refusal To Consent

I DO NOT give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____

Signature of Parent/Guardian