

GIRARD CITY SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION FORM

COMPLETING THIS FORM IS A REQUIREMENT OF THE STATE OF OHIO

PURPOSE: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority.

Student Name _____ Address _____ Grade _____

Phone _____ Date of Birth _____ Social Security No. _____

Student resides with (Name of Parent(s) or guardian) _____

Mother's Name _____ Place of employment _____ Phone _____

Father's Name _____ Place of employment _____ Phone _____

People to contact if we are unable to reach parent(s):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Please list below any facts concerning child's medical problems/history, including allergies, serious injuries, medication being taken and physical impairments to which school should be alerted. _____

I give the school nurse permission to administer Tylenol or Advil (2) tablets to my child if the need arises.

Signature Parent/Guardian _____ Date _____

Part I: TO GRANT CONSENT OR PART II TO REFUSE CONSENT
COMPLETE EITHER PART I OR II.

Part I: I Grant consent for emergency treatment NOT major treatment or surgery, to my family Physician _____ or family dentist

_____ or transfer to preferred hospital _____

Signature parent/guardian _____ Date _____

Part II: I refuse consent for emergency medical treatment and wish the school to carry out the following directions: _____

Signature parent/guardian _____ Date _____