Circle One
Bus No.______AM/PM
Bus No. _____ AM/PM
Other _____________

EMERGENCY MEDICAL AUTHORIZATION FORM

O.R.C. 3313.712

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.

Student's Name ________________________ Birthdate______________ Grade ______________

Home Address________________________ PO Box #________________________

City, State/Zip ________________________ Teacher________________________

Student resides with (circle all that apply) mother father step-parent guardian other ______________
If custody is involved with whom is the student living?________________________

List the names (first and last names) of those who have authority to make decisions in an emergency situation involving the student.
Indicate on the line to the left of the name the order in which you would like contacts to be made (1st, 2nd, etc)

____ Mother: ______________ Home Phone:______________ Work Phone:______________ Cell Phone:______________
Place of Employment______________________

____ Father: ______________ Home Phone:______________ Work Phone:______________ Cell Phone:______________
Place of Employment______________________

____ Step-parent: ______________ Home Phone:______________ Work Phone:______________ Cell Phone:______________
Place of Employment______________________

____ Guardian: ______________ Home Phone:______________ Work Phone:______________ Cell Phone:______________
Place of Employment______________________

____ Other Contact : ______________ Home Phone:______________ Work Phone:______________ Cell Phone:______________
Place of Employment______________________

Siblings: Name:________________________ Grade:__________ School:______________
Name:________________________ Grade:__________ School:______________

Permission for picture publication (Newspaper, school articles, etc.): Yes______ No ______
Permission for Tylenol for headache (Grades 9 through 12 only): Yes______ No______ **Must fill out district medication sheet.**

COMPLETE **ONLY ONE** OF THE FOLLOWING: 1. Consent for Treatment or 2. Refusal to Consent

1. CONSENT FOR TREATMENT:
I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Physician: ________________________
Office Phone: ______________
Preferred Dentist: ________________________
Office Phone: ______________
Medical Specialist: ________________________
Office Phone: ______________
Preferred Hospital: ________________________

2. 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 the following action:
____
____
Parent/Guardian Signature______________
____
Date:______________

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 the preferred doctor indicated, 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 surgery.

MEDICAL HISTORY: Facts concerning the child's medical history including **allergies, medication being taken, and any physical impairment** of which a physician and/or school personnel should be alerted:

____
____

Parent/Guardian Signature:________________________ **Date:** ______________
(consent for treatment)

School staff may be notified of above medical conditions unless otherwise notified.

SWITZERLAND OF OHIO LOCAL SCHOOL DISTRICT
PARENT'S ANNUAL REPORT TO THE SCHOOL

Name____ Grade____________

Date__________________ Parent Email____

This form **must** be returned completed and signed, whether any changes are to be made or not.

Dear Parents/Guardians:

Changes, additions and reminders are necessary to keep your child's health record up-to-date. This information helps the nurses and teachers to better understand your child.

Transportation: Bus Driver's Name___________________ Drives to school______ Pick up/drop off_____

EARLY/EMERGENCY DISMISSAL INFORMATION

Go to the home of____________________________________ Phone________________

Address____

Responsible person or neighbor (besides parents/guardians) to transport child with minor illness or injury

First Choice:____ Phone________________

Second Choice:______________________________________ Phone________________

Please report and explain (attach a sheet if necessary):

Changes in either parents/guardians employment____
New immunizations, boosters and future medical appointments____________________________
Dental work (braces, etc.)____
Operations/bone fractures____
Allergies and illnesses (diabetes, etc.)____
Bee sting allergy (LIST SPECIAL TREATMENT)____
Childhood diseases (chickenpox)____
Visual/hearing (glasses, tubes, etc.)____
Family changes (divorce, death, etc.)____
Taking medication - What and When?____

1. If your child will be taking short-term medication (antibiotics, etc.) at school, we need written permission (a note).
2. A special form is needed for long-term medication, which can be obtained at your school.

Physical Education Health Information:

1. Should your child be restricted in Physical Education Activities? YES or NO If yes, please explain,
   ____
2. Please check below if your child has or has had any of the following: Rheumatic Fever______ Heart Disease______ Heart Murmur_____ Diabetes______ Polio______ Hernia_____ Handicaps______ None______
3. Please contact your PE teacher if anything changes occur during the school year.
   If assistance is needed, feel free to contact your school principal, nurse, teacher or physical education instructor.

____
Parent/Guardian's Signature