Emergency Medical Authorization Form
Campbell City Schools

www.campbell.k12.oh.us

Please print clearly

School: ____________________

Grade: ____________________

Custody Alert: ______________

Student Name:____ Birth date:____________________

Address: ____ Home Phone:________________________

Student lives with (check all that apply): _____Mother/Father _____Mother only _____Father only _____Mother/Stepfather _____Father/Stepmother _____Grandparents _____Legal Guardian _____Other Please Specify: __________________

Who has legal custody of the child (please X one): ___ Both Parents ___Mother Only ___Father Only ___Shared ___Other:__________________ (Please provide legal documents if available.)

Anyone listed on the form is authorized to pick up student from school and may be contacted in the event of a medical emergency

Parent/Guardian Information	Parent/Guardian Information
Name:______________________________	**Name:**______________________________
Relationship to Student (please specify):______________	**Relationship to Student (please specify):**______________
Phone Number: ______________________	**Phone Number:**______________________
What language(s) do you speak: ______________	**What language(s) do you speak:** ______________
Are you currently in the military?_________ **Are you active duty?**______	**Are you currently in the military?**_________ **Are you active duty?**______
Parent/Guardian Email Address: ______________________________	**Parent/Guardian Email Address:** ______________________________

Other Authorized Contacts (minimum of 3) Able to pick up/remove student from school

Name	Relationship	Language Spoken	Phone Number

Name and grade of siblings attending Campbell City Schools

Name: ______________________________________ Grade: __________________

Name: ______________________________________ Grade: __________________

Name: ______________________________________ Grade: __________________

Name: ______________________________________ Grade: __________________

Student Name:____ **Birthdate:**____________________

Students Health Alerts: Allergies, Medications, Physical impairments, or relevant medical history:
___Asthma ___Inhaler ___Diabetes ___Seizures ___Food Allergies ___ Medication Allergies ___Bee Sting ___Epipen
___OTHER Please explain____________________

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The school nurse may administer, including but not limited to, (1-2) Tylenol, Ibuprofen, Stomach aid & or cough drops to my son/daughter in the event my child's symptoms indicate a need.

Circle one: YES / NO

☆ **Signature of Parent/Guardian:**_______________________________________ **Date:**______________

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PART 1 - **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: _____________________________ Emergency Room 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:

☆ **Signature of Parent/Guardian:** ____________________________________ **Date:**________________

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PART 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:____

Signature of Parent/Guardian:_____________________________________ **Date:**__________________