Logan-Hocking Local School District Emergency Medical Authorization Form

Facility: ______ Grade or N/A: ______ Date of Birth: ______

Name ______ (Last) ______ (First) ______ (Middle)

Address ______ (Street) ______ (City) ______ (State) ______ (Zip)

Home Phone: ______ Cell Phone: ______

Purpose - To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. OR to have more information regarding someone during a time of emergency while utilizing the Chieftain Center.

In the event of an emergency or the student becomes ill at school, name of relative or childcare provider to be contacted if you cannot be reached.

	Contact #1	Contact #2	Contact #3
Name:			
Relationship:			
Phone:			
Address:			
City, State, Zip			

PART I OR II MUST BE COMPLETED

PART I: GRANT TO CONSENT

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

		Phone	
Physician:		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 the above named doctor, or in the event the designated practitioner is not available by another licensed physician or dentist; and (2) the transfer of the child or myself to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring on 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: STUDENTS ONLY

Allergies? (Food, Animals, Medications) No ______ Yes (To what) ______

Type of Reaction: ______ Life Threatening: ______

Asthma:	Y or N	If 'yes,' is an inhaler used?	Y or N	How often?
Glasses/Contacts:	Y or N	Is inhaler needed at school?	Y or N	(Medication form must be completed)

Do medications need to be administered at school? (STUDENTS ONLY) Y or N

Medication(s) taken (on a REGULAR basis) including at HOME and SCHOOL and reason being taken STUDENTS ONLY:

______

Physical impairments (Heart, Epilepsy, Hearing, Diabetes, etc.): ______

Other health problems to which a physician should be alerted:

I do hereby consent for emergency medical treatment of myself or my child, in the event of illness or injury requiring emergency treatment.

______ Date: Signature or signature of Residential Parent: ______

(Street) (City) (State) (Zip)

PART II: REFUSAL TO CONSENT

I do NOT give consent for emergency treatment of myself or my child, in the event of illness or injury requiring emergency treatment.

I wish the school authorities to take the following action: ______

______ Date: Signature or signature of Residential Parent: ______

(Street) (City) (State) (Zip)