Pickaway County Board of DD
Brooks-Yates School
1005 South Pickaway Street
Circleville, OH 43113
740-474-1124

Emergency Medical Authorization Form

School Name:_____

Students Name:_____ DOB: _____

Address:_____

City: _____Zip:_____

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 can not be reached.

Residential Parent or Guardian:

Mother's Name: _____
First Last
Home Phone #_____
Work Phone #_____
Cell Phone #_____
E-mail _____

Father's Name:_____
First Last
Home Phone #_____
Work Phone #_____
Cell Phone #_____
E-mail _____

Other's Name:_____
First Last
Home Phone #_____
Work Phone #_____
Cell Phone #_____
E-mail _____

Name of Relative or Childcare Provider:

Name:_____ Relationship:_____

Address:_____ Daytime Phone #_____

City:_____Zip:_____ Cell Phone #_____

Part I or II must be completed
(see reverse side)

7/12

Part I: **TO GRANT CONSENT**

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

Physician Name:_____ Phone #_____

Address:_____

Dentist Name:_____ Phone #_____

Address:_____

Medical Specialist:_____ Phone #_____

Address:_____

Local Hospital:_____ ER Phone #_____

Address:_____

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 doctors, or, in the event the designated preferred practioner 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 to 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:

Medical History: Diagnosis, surgeries, etc.)_____

_____

Allergies:_____

Current medications:_____

_____ _____

Date Signature of Parent/Guardian

Address:_____

City:_____ Zip:_____

_____

Part II: **REFUSAL TO CONSENT**

I do **not give consent** for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take the following action:

_____

_____

_____ _____

Date Signature of Parent/Guardian

Address:_____

City:_____ Zip:_____