

NICHOLAS SCHOOL –EMERGENCY MEDICAL/PARENT AUTHORIZATION FORM
---PLEASE PRINT---

STUDENT INFORMATION

According to Ohio law, each school is required to maintain emergency medical information. Please read very carefully and fill out completely.

NAME: LAST _____ FIRST _____

MIDDLE INITIAL _____ SOCIAL SECURITY # _____

STREET ADDRESS _____ CITY _____ ZIP CODE _____

PHONE NUMBER _____ BIRTHDATE _____ AGE _____

PARENT/GUARDIAN INFORMATION

NAME _____ RELATIONSHIP _____

STREET ADDRESS _____ CITY _____ ZIP CODE _____

SOCIAL SECURITY # _____

HOME/CELL PHONE NUMBER _____ WORK PHONE _____

An emergency may arise at school. The school will attempt to call the home/cell first, then work. If there is no phone or no answer, please list at least 3 contact persons to whom we may release your child.

ADDITIONAL CONTACTS

We will contact in the order listed:

1. NAME _____ RELATIONSHIP _____

HOME/CELL PHONE _____ WORK PHONE _____

2. NAME _____ RELATIONSHIP _____

HOME/CELL PHONE _____ WORK PHONE _____

3. NAME _____ RELATIONSHIP _____

HOME/CELL PHONE _____ WORK PHONE _____

4. NAME _____ RELATIONSHIP _____

HOME/CELL PHONE _____ WORK PHONE _____

MEDICAL INFORMATION

Important – Please fill out completely.

FAMILY DOCTOR _____ TELEPHONE _____

STREET ADDRESS _____ CITY _____ ZIP _____

FAMILY DENTIST _____ TELEPHONE _____

STREET ADDRESS _____ CITY _____ ZIP _____

MEDICAL SPECIALIST _____ TELEPHONE _____

STREET ADDRESS _____ CITY _____ ZIP _____

PREFERRED HOSPITAL _____ CITY _____

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Please complete Part I or Part II, NOT BOTH SECTIONS.

The purpose of this form is to enable parents of guardians to authorize or refuse the provision of emergency treatment for children who become ill or are injured while under school authority when parents or guardians cannot be reached.

PART I - GRANT CONSENT

In the event reasonable attempts to contact me or my designee have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by family physician or dentist. In the event the designated practitioner is not available, authorization is granted for treatment by another licensed physician or dentist.

The 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 or health problems to which a physician should be alerted are:

PARENT/GUARDIAN SIGNATURE

DATE

PART II - REFUSAL TO GRANT CONSENT

I **DO NOT** give my permission for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

PARENT/GUARDIAN SIGNATURE

DATE