KIRTLAND SCHOOLS
9252 CHILLICOTHE ROAD
KIRTLAND, OH 44094

EMERGENCY MEDICAL AUTHORIZATION (FORM 5341 F1)

TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

PLEASE PRINT AND USE BLUE/BLACK INK

The purpose of this form is 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 Name_____ Date of Birth_____ Home Phone_____
(Last) (First) (Area Code)
Address _____ City_____ Zip Code_____

School _____ Homeroom Teacher _____ Grade_____

CHILD CUSTODY: Are there any court papers assigning custody of this child? Yes_____ No _____
If yes, it is necessary for us to have a copy on file.

Parent or Guardian (Residential) Student lives with _____

Mother _____ Home Phone _____ Work Phone_____ Cell _____

Father _____ Home Phone_____ Work Phone _____ Cell _____
(PLEASE NOTE WHICH PARENT AND PHONE NUMBER SHOULD BE CALLED FIRST)

Mother's place of employment _____ Father's place of employment _____

Siblings in district and grade _____

In situations where the parent cannot be reached the student may be released to the following:

Name _____ Relationship _____ Daytime Phone _____ Cell _____

Name _____ Relationship _____ Daytime Phone _____ Cell_____

Name _____ Relationship _____ Daytime Phone _____ Cell_____

Allergies, health concerns and medications to which the **school** should be alerted:

_____

_____

REVERSE SIDE <u>MUST</u> BE COMPLETED AND SIGNED

Required by Ohio Revised Code Section 3313.712 Expires: September 08, 2018

PART I <u>OR</u> PART II MUST BE COMPLETED AND SIGNED

PART I – TO GRANT CONSENT

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

Doctor _____ 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 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:

Allergies _____

Health Concerns _____

Medications _____

Signature of custodial/residential parent _____

Address _____ Date _____

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II – 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 custodial/residential parent _____

Address _____ Date _____

* *

Cross Reference: Board Policy 5341