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:

____

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REVERSE SIDE MUST BE COMPLETED AND SIGNED

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:

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Signature of custodial/residential parent ____

Address ____ Date _________________

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Cross Reference: Board Policy 5341