Ashtabula Area City Schools

EMERGENCY MEDICAL AUTHORIZATION

PLEASE PRINT CLEARLY:

PURPOSE: To enable parents and guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents or guardians can not be reached.

STUDENT'S NAME ______________________________
Last First Middle

ADDRESS ______________________________

CITY/STATE/ZIP ______________________________

BIRTHDATE ______________ **GRADE** __________ **TEACHER (K-6)** ______________

CONTACT THE FOLLOWING IN CASE OF EMERGENCY – COMPLETE ALL SPACES

Include area code for all phone numbers

1. ______________________________
Parent/Guardian-- Mother

______ / ______ / ______
Home Phone Cell Work

____
Email address

2. ______________________________
Parent/Guardian – Father

______ / ______ / ______
Home Phone Cell Work

____
Email address

3. ______________________________
Name/ Relationship to Student

______ / ______ / ______
Home Phone Cell Work

4. ______________________________
Name/Relationship to Student

______ / ______ / ______
Home Phone Cell Work

5. **TO GRANT CONSENT**: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physicians below or, if they are not available, by another licensed physician or dentist. I give my consent for my child to be transferred to the hospital below, or 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 of such surgery, are obtained prior to the performance of such surgery.

Facts concerning my child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ______________________________

____

____
Preferred Physician/ Phone number

____
Preferred Dentist/ Phone number

____
Preferred Hospital / Phone number

____
Medical Specialist / Phone number

Signature of Parent/Guardian ______________________________ Date ______________

6. **TO REFUSE CONSENT**: (Fill out **ONLY** if you have not completed #5 above)

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 Parent/Guardian ______________________________ **Date** ______________

In a life-threatening situation, emergency services will be called.

Please Complete Back of Form

ASHTABULA AREA CITY SCHOOLS
STUDENT MEDICAL HISTORY UPDATE

STUDENT'S NAME ____

Please check the appropriate box if your child experiences the following:

Allergies to Food Bee stings Medication Other

Describe reaction: ____

Please specify what your child is allergic to: ______________________________

Treatment for allergic reaction: ______________________________

Does your child have an Epipen: Yes No

If yes, will you provide one to be available at school? Yes* No

Asthma Does your child use an inhaler? Yes No

Diabetes Insulin Dependent? Yes No

Has student been taught self care? Yes No

Epilepsy/Seizures Will medication be needed at school? Yes No

NONE OF THE ABOVE

- **A medication form must be completed and returned before any medication can be dispensed at school. The form is available on our website or can be obtained from the office or school nurse.**

Brothers/Sisters in the District

Name/Grade	Name/Grade	Name/Grade

02/10/2017