

Please Print

Dayton Public Schools EMERGENCY MEDICAL AUTHORIZATION

Teacher (or) Room/Grade _____ School _____ Student's ID Number _____ Date _____

Student's Last Name _____ First _____ Middle _____ Sex _____ Date of Birth _____ Home Phone _____

Student's Address _____ Zip _____

Father/Guardian _____ Work Phone _____

Mother/Guardian _____ Work Phone _____

ALTERNATIVE PERSONS TO BE NOTIFIED WHEN PARENTS CANNOT BE REACHED

(1) _____ Name _____ Phone _____ (2) _____ Name _____ Phone _____

EITHER PART I OR PART IV MUST BE COMPLETED

PART I: CONSENT GRANTED

In the event reasonable attempts to contact _____ at _____ or _____ at _____ have been unsuccessful, I hereby give my consent for: (1). Administration of any treatment deemed necessary by Dr. _____ or Dr. _____ 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: _____ or any hospital reasonably accessible.

THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS/DENTISTS CONCERNING THE CHILD'S MEDICAL HISTORY OR ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED. THE DAYTON PUBLIC SCHOOLS IS WORKING IN COLLABORATION WITH THE CENTER FOR HEALTHY COMMUNITIES TO IMPROVE ACCESS TO HEALTHCARE. TO DO THIS WORK, WE SHARE INFORMATION WITH OTHER LICENSED HEALTHCARE PROVIDERS AND/OR MEDICAID.

Has your child ever had (Please (✓) check all that apply):

Heart Trouble _____ Tuberculosis _____ Epilepsy (Seizures) _____ Diabetes (Sugar) _____ Other _____

Explain any allergy or disease causing difficulty: _____

X _____ Signature of Parent/Guardian _____ Address _____ Date _____

PART II: HEALTH INSURANCE

Do you have health insurance for your child(ren) age 19 and younger?
 Yes No

PART III: STUDENT'S MEDICATIONS

Does child regularly take prescribed medications? Yes No
 If yes, please list medications: _____

Are any medications given during school hours?
 Yes No
 (If yes, please obtain the Medication Administration form at your child's school.)

PART IV: CONSENT REFUSED

I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OF INJURY REQUIRING EMERGENCY TREATMENT, I WISH THE SCHOOL AUTHORITIES TO TAKE NO ACTION OF TO:

 Signature of Parent/Guardian

 Address

 Date