Emergency Medical Authorization

Purpose: 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's Name____Birthdate_____________Grade___________

Address____Teacher/Homeroom____________________

City/State/Zip____

Bus Number (if applicable)_______________________________________

Student Resides with (ŏKŜŏʅ ǘKl·ǘ l·LJLJfè): ☐ Mother ☐ Father ☐ Grandparent ☐ Guardian ☐ Other_________________

****

List only the names (first and last) of those who have authority to make decisions in an emergency situation involving this student. Then, indicate on the line to the left the order in which you desire contact attempts to be made based on availability (i.e., 1st, 2nd,

_____Mother_____________________________________Home/Cell #__________________Work#_______________

_____Father_____________________________________Home/Cell #__________________Work#_______________

_____Grandparent________________________________Home/Cell #__________________Work#_______________

_____Guardian___________________________________Home/Cell #__________________Work#_______________

_____Relative or Alternate (i.e., child care provider, aunt, etc.) Relationship to Child____________________________

Name_______________________________________Home/Cell #__________________Work#______________

Complete ONLY ONE of the following: 1) Consent for Treatment OR 2) Refusal to Consent

1] ***CONSENT FOR TREATMENT***

I, hereby give consent for the following medical care providers and local hospital to be called:

Preferred Physician________________________________

Office #____

Preferred Dentist__________________________________

Office #____

School Nurse ☐ YES ☐ NO

Office # 740-596-5218

Preferred Hospital________________________________

ER# ____

2] ***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:

Parent/Guardian Signature_________________________

Address____

Date____

****

AND 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 preferred doctor indicated OR 2) in the event the designated preferred practitioner is not available, by another licensed physician or dentist **AND** 3) the transfer of the child to any hospital 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.

MEDICAL HISTORY: Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment of which a physician and/or school personnel should be alerted include:____

____

____ ____________________________

Parent/Guardian Signature Date

****

Field Trip Permission Slip

Student Name____Grade_________ Homeroom Teacher______________________

I give my son/daughter permission to partiipate in ALL supervised field trip activities this school year unless revoked in writing by the parent/guardian prior to the scheduled field trip.

Parent/Guardian Signature____Date________________________

Vinton County Local School District
Medical History and Authorization Form

Student's Name_____Age_____Date_____/_____/_____
School_____Teacher_____Grade_____
Medication Allergies_____
Allergic to tape, band-aids, or latex?_____Yes_____No
Please Check any of the following health problems that apply to your child.
_____Asthma; Inhaler_____Yes_____No; Name of inhaler_____
_____Diabetes
_____Seizures or Epilepsy
_____Attention Deficit Disorder or Hyperactivity
_____Migraines
_____Heart Problems
_____Abdominal Problems
_____ Musculoskeletal Problems
_____Other; Explain_____
Does your child require an Epi-Pen?_____Yes_____No
If yes, please explain _____
_____
Does your child take any prescription medications?_____Yes_____No
Name, dosage and reason why taking
medicine_____

Has your child had chickenpox?_____Yes_____No Chicken Pox vaccine?_____Yes _____No
Does your child wear _____Glasses_____Contacts_____Hearing Aids?
Has your child broken any bones?_____Yes_____No If yes, Please explain_____
_____
Does your child have food allergies? **(We must have something from MD for auditor)**
_____Peanuts _____Milk _____Milk Products (Please List)_____
_____Strawberries _____Red (or any food coloring(Please list))_____
_____Eggs _____Wheat _____Cinnamon
May we apply?:
Hydrogen Peroxide to clean cuts _____Yes _____No
Triple Antibiotic Ointment or Neosporin for small cuts _____Yes _____No
Caladryl (Calamine) lotion for rash, _____Yes _____No
Sting Kill Swabs for bee stings _____Yes _____No
Orajel for toothaches _____Yes _____No
Hydrocortisone Cream for itching, poison ivy, insect bites, etc. _____Yes _____No
Vaseline for chapped lips _____Yes _____No
Pink Eye Relief _____Yes _____No
Aloe Vera for sunburn _____Yes _____No

OHIO STATE LAW: WE CAN NOT GIVE ANY MEDICINE, PRESCRIPTION OF OVER-THE-COUNTER, WITHOUT A PHYSICIAN'S ORDER

Parent Signature_____