

(A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

If a parent does not wish to give such written permission, he/she shall indicate in the proper place on the form the procedure he wishes school authorities to follow in the event of a medical emergency involving his/her child.

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section.

(B) The emergency medical authorization form provided for in division (A) of this section is as follows: (see reverse side)

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 _____

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Student Resides with (): 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, etc.)

_____ 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 participate 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 _____