LOUISVILLE CITY SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION

Teacher _____

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. This form is required by law to be kept on file.

Student Name _____ **Home Phone** _____
Last *First* ***Full*** *Middle*

Current Address _____ **City** _____, **OH Zip** _____

Gender: M / F (*Circle one*) Date of Birth _____ **School** _____ **Grade** _____ **Bus #** _____

IF PARENTS ARE DIVORCED OR SEPARATED:

Who has legal (court appointed) custody? _____

Is there a restraining order? _____ **Yes** _____ **No (*Select one*)**

***If yes, the restraining order is against whom*?** _____

(Updated copies of these documents MUST be provided to the School)

MY CHILD MAY BE RELEASED to the following individuals if school authorities cannot reach me:
***(Please list in preferred calling order; identification from these individuals will be required*)**

1. _____ **Relationship** _____ **Phone** _____

2. _____ **Relationship** _____ **Phone** _____

3. _____ **Relationship** _____ **Phone** _____

Relative or other daycare provider:

Name _____ **Daytime Phone** _____

MY CHILD MAY NOT BE RELEASED to the following individuals:

1. _____ **2.** _____

Mother's Name _____ **Work Phone** _____ **Home Phone** _____

Address (*If different from student*) _____

Email Address _____ **Cell Phone** _____

Legal Stepfather's Name _____ **Stepfather's Work Phone** _____

Father's Name _____ **Work Phone** _____ **Home Phone** _____

Address (*If different from student*) _____

Email Address _____ **Cell Phone** _____

Legal Stepmother's Name _____ **Stepmother's Work Phone** _____

Guardian's Name _____ **Work Phone** _____ **Home Phone** _____
(*If other than parents)*

Email Address _____ **Cell Phone** _____

PARENT/GUARDIAN….PLEASE COMPLETE AND SIGN THE REVERSE SIDE

PLEASE COMPLETE PART I OR PART II BELOW – NOT BOTH

PART I – TO GRANT CONSENT

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

Doctor's Name _____ Phone _____

Dentist's Name _____ Phone _____

Medical Specialist's Name _____ Phone _____
(*For chronic health conditions*)

Hospital (*Preferred*) _____ Emergency Room 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 above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician, or dentist; and (2) 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 taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

The School Nurse may share health information with appropriate school personnel to aid in present and future education decisions.

Parent/Guardian Signature _____ Date _____

PART II – TO REFUSE CONSENT
(*Do not complete if you completed Part I above*)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

Parent/Guardian REFUSAL signature _____ Date _____

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