ELEMENTARY Student Name: _____

NEW MIAMI LOCAL SCHOOL DISTRICT

EMERGENCY MEDICAL AUTHORIZATION Teacher Name: _____

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 Name _____ Male / Female

Last First Middle

Address _____ Phone _____ Grade _____

City, State, Zip Code_____ Date of Birth _____

[ ]Mother [ ]Grandmother [ ]Guardian [ ]Step Parent [ ]Other

Parent Name _____ Home Phone _____ Work Phone _____

Address (if different from student) _____ Cell/ Pager _____

Email address _____

[ ]Father [ ]Grandfather [ ]Guardian [ ]Step Parent [ ]Other

Parent Name _____ Home Phone _____ Work Phone _____

Address (if different from student) _____ Cell/ Pager _____

Email address _____

Person (s) who may be notified and to whom your child may be released if school authorities cannot reach you.

Parents will be contacted before students are released.

1. _____Home Phone _____ Cell_____
2. _____Home Phone _____ Cell_____
3. _____Home Phone _____ Cell_____

Does your child have Health Insurance? __ Yes __ No Company/ Policy Number_____

Does your child have Dental Insurance? __ Yes __ No Company/ Policy Number_____

Doctor _____ Phone Number_____

Dentist _____ Phone Number _____

Preferred Local Hospital _____

Please list all medications and dosage your child is presently taking at home as well as at school:_____

_____

Please check all that applies to your child: ☐Allergies (Food, insects, medication, environmental, animals) _____

_____

☐Heart Condition ☐Diabetes ☐Asthma ☐Seizure disorder ☐ADD/ADHD ☐Migraines ☐Depression

☐Other (specify) _____

☐Hearing Problems: ☐Left Ear ☐Right Ear ☐Hearing Aid(s) ☐Vision problems Wears glasses ☐Contact Lenses

☐ Needs Preferential seating ☐Any other information needed concerning my child: _____

IT IS PARENTS /GUARDIAN RESPONSIBILITY TO CONTACT THE SCHOOL WHEN UPDATES ARE NEEDED.

~ OVER ~

TO GRANT CONSENT:

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) the transfer of the child to any hospital reasonably accessible.

I give my permission to New Miami Local School to share information relevant to my child's health condition with appropriate personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

This authorization does not cover major medical 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 being taken and any physical impairments to which a physician should be alerted have been listed.

Signature of Parent/ Guardian _____ Date_____

Address _____ Zip Code _____

REFUSE TO CONSENT

I do NOT give 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 NO action or to: _____

_____

Signature of Parent/Guardian _____ Date_____

Address _____ Hamilton, Ohio Zip Code_____

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PERMISSION SLIP

My child, _____, has my permission to accompany the teachers and students of
(Child's Full Name)

New Miami Elementary School on field trips during the _____ school year.

Grade:_____

_____ _____

Signature of Parent or Legal Guardian **Date**