

**Middle/High School**

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

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.**

**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 Middle/High School on field trips during the \_\_\_\_\_ school year.

Grade: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian Date