EMERGENCY MEDICAL AUTHORIZATION #5330 F

Pandora-Gilboa Local Schools School Year_____ Grade_____

Student Name _____
Address _____ City _____
Zip Code _____Home Phone# _____
E-mail Address_____ Birthdate _____

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.

PARENT OR GUARDIAN:

_____ _____
Mother's Name Mother's Daytime Phone Number(s) & Name of Employer & e-mail address

_____ _____
Father's Name Father's Daytime Phone Number(s) & Name of Employer & e-mail address

_____ _____
Any Other Parents/Guardians Daytime Phone Number(s) & Relationship

If this is a divorced or separated home, name of custodial residential parent on document: _____
County and state where document is filed:_____
If not living with person of legal custody, state name of person with whom child is living:
Name_____ Relationship_____
Address_____

RACIAL/ETHNIC CATEGORY:
Is student of Hispanic/Latino heritage? Yes/No If "No" choose one or more of the following racial groups:
White___ Black or African American___ Asian ___ American Indian or Alaska Native___
Native Hawaiian or Other Pacific Islander _____

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If your child becomes ill during the school day and you cannot be reached, please list persons you wish notified to pick your student up. Please list as many as possible.

Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____
Name _____ Phone # _____ Relationship _____

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FIELD TRIP PERMISSION: _____(student name) has my permission to go with a school chaperoned group on field trips away from the building.

Parent/Guardian Signature _____

PUBLIC RELEASE INFORMATION: The Pandora-Gilboa Schools have permission to use my child's name and photograph in any school related news releases to area newspapers. I/We wish the article to read _____son/daughter of _____.

Parent/Guardian Signature _____

INTERNET PERMISSION: Students in some classes at Pandora-Gilboa Schools may be publishing on web pages on the internet. The items listed below may be included on web pages. Please circle yes or no for each item. **Student's last names and addresses will not be released.**

***YES** ***NO** CREATIVE WRITING BY YOUR STUDENT
***YES** ***NO** ART WORK BY YOUR STUDENT
***YES** ***NO** PICTURES OF YOUR STUDENT

I give permission for my student to publish on the World Wide Web unless indicated no on the above items.

Parent/Guardian Signature_____

Part I OR II must be completed

Part I

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 _____ Phone # _____

Local Hospital _____ Phone # _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above-named doctor, 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.

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, medication being taken, and any physical impairments to which a physician should be alerted are as follows: _____
_____
_____
_____

Date _____ Signature of Parent/Guardian _____

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Part II – DO NOT complete part II if you completed part I

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:

_____

Date _____ Signature of Parent/Guardian _____

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State of Ohio
County of _____

Sworn to and subscribed before me, a Notary Public, this _____day of _____, 20____.

_____
Notary Public