

**AUSTINTOWN LOCAL SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION FORM**

As Mandated by House Bill 639

For Grades 7-12. Grade: _____

Student Name: _____ Date of Birth: _____
Address: _____ Phone: _____

CUSTODIAL PARENT(S) OR GUARDIAN

Mother's Name: _____ Daytime Phone: _____
Home Address: _____ Employer: _____
Father's Name: _____ Daytime Phone: _____
Home Address: _____ Employer: _____

CONSENT FOR NURSING / HEALTHCARE

____ **Yes** - I consent to the expanded school health services provided by the Fitch School based Health Center. I understand that I will be contacted with the results of examinations and treatment plans.

____ **No** - Please limit the nursing care provided for my child to traditional school nurse duties.

Generic Tylenol Consent

Purpose - To enable parents and guardians to authorize the provision or emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

____ **Yes** - I give my permission for generic Tylenol to be given to my child.

____ **No** - I do not give permission for generic Tylenol to be given to my child.

PART I --- To Grant Consent

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

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Local Hospital: _____ Phone: _____
Emergency Room: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration or any treatment deemed necessary by above doctor, or in the event to 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 dentist, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

Date: _____ Signature: _____

PART II --- 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:

Notes:

Date: _____ Signature: _____

Parent or Guardian: In the event that the clinic staff needs to contact me during school hours, I can be contacted at the following numbers: (H) Home, (W) Work, (C) Cell, (P) Pager. Please list all phone numbers with the Area Code first!

1st Choice:	Name: Relationship:	Number with area code: H: W: C: P:
2nd Choice:	Name: Relationship:	Number with area code: H: W: C: P:
3rd Choice:	Name: Relationship:	Number with area code: H: W: C: P:

Alternate Contacts: In the event you are unable to reach me at the above numbers you have my permission to contact the following alternates. They have my permission to receive health care information regarding my child and can take them home during school hours if needed. (H) Home, (W) Work, (C) Cell, (P) Pager. Please list all phone numbers with the Area Code first!

1st Choice:	Name: Relationship:	Number with area code: H: W: C: P:
2nd Choice:	Name: Relationship:	Number with area code: H: W: C: P:

HEALTH CARE PROVIDER INFORMATION

Preferred Physician:	Name:	Number with area code:
Preferred Dentist:	Name:	Number with area code:
Health Insurance Plan / Company:	Name: Plan Number:	Number with area code:

Please list facts concerning the child's medical history including allergies, Medications being taken, and any physical impairments to which a physician should be alerted:

Circle Whichever Applies to your Child: Diabetes - Asthma - Bee Sting - Peanut Allergy - Heart Condition - ADD - Other: _____

May the school nurse share this information with teacher? _____ Yes _____ No

Please notify the clinic staff immediately if phone number (s) change at any time during the school year.

Date: _____ Parent or Guardian Signature: _____