

LIMA CITY SCHOOLS
 Dr. Earl A. McGovern Educational Center
 755 St. Johns – Post Office Box 2000
 Lima, OH 45802-2000

Teacher Name: _____

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parent(s) cannot be reached.

Student's Name _____ School _____
Last First Middle Initial

Address _____
Street City State Zip Code

Phone _____ D.O. B. _____ Social Security # _____

Residential Parent or Guardian

Mother _____ Day time phone # _____

Father _____ Day time phone # _____

Other Name _____ Day time phone # _____

Name of Relative or Child Care Provider _____

Phone # _____ Relationship _____

Address _____
Street City State Zip Code

Part I or Part II below must be completed.

DO NOT SIGN IN BOTH PLACES.

Part I: Parent/Guardian Consent Authorization

In the event attempts to contact me at any of the phone numbers I have provided are unsuccessful, I hereby give my consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone # _____

Dentist _____ Phone # _____

Medical Specialist _____ Phone # _____

Local Hospital _____ Phone # _____

List any facts concerning the child's medical history, including allergies, medications being taken and any physical impairment(s) to which medical care providers should be alerted: _____

I give my consent for the **SCHOOL NURSE** to give my child Tylenol or Ibuprofen for pain or fever. I give my consent for (1) the administration of any treatment deemed necessary by the medical care providers listed or in the event the designated preferred medical care provider is not available, by another licensed physician, dentist or medical specialist; and (2) the transfer of the child to the local hospital listed or any hospital reasonably accessible.

This authorization DOES NOT cover major surgery, unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the surgery.

Parent/Guardian Signature _____ Date _____

Address _____
Street City State Zip Code

DO NOT SIGN IN BOTH PLACES.

Part II: Refusal to Consent

DO NOT complete if you have completed Part I.

I **DO NOT** give my consent for emergency medical or dental treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Parent/Guardian Signature _____ Date _____

Address _____
Street City State Zip Code

**** YOU MUST COMPLETE THE BACK OF THIS FORM. ****

**EMERGENCY MEDICAL AUTHORIZATION
SECTION 3313.712**

Annually, the board of education of each city, exempted village, local and joint vocational school district shall, before the first day of October, provide the parent of every pupil enrolled in schools under the board's jurisdiction an emergency medical authorization form.

Thereafter, the board shall, within thirty (30) days after the entry of any pupil into a public school in this state for the first time, provide the parent, either as part of any registration form which is in use in the district or as a separate form which is in use in the district, a copy of the emergency medical authorization form.

When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local or joint vocational school district to which the pupil is transferred. Upon request of the pupil's parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form or to file a new form.

If a parent does not wish to give such written permission, the parent shall indicate in the proper place on the form the procedure he/she wishes school authorities to follow in the event of a medical emergency involving his/her child/

Even if a parent gives written consent for emergency medical treatment, when a pupil becomes ill or is injured, and requires emergency medical treatment while under school authority or while engaged in an extracurricular activity authorized by the appropriate school authorities, the authorities of the pupil's school shall make reasonable attempts to contact the parent before treatment is given. The school shall present the pupil's emergency medical authorization form or a copy of the pupil's medical authorization form to the hospital or medical care provider rendering treatment.

Nothing in the section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section.

FIELD TRIP PERMISSION

Our classes will be participating in various field trips during the school year. All field trips will be properly supervised by the classroom teacher and parent transportation will be provided for the entire class.

In order to simplify the process of signing and returning permission slips for each field trip, we request that each parent sign this permission slip below which will serve for all scheduled field trips throughout the year. Even though you are granting this permission only once, we will notify you of each field trip so that you are always aware of these activities.

My child, _____ has permission to accompany his/her classroom teacher on field trips, as approved by the building Principal. I understand that I will be notified prior to such activities by the classroom teacher. This permission is granted for the entire school year.

Parent/Guardian Signature

Date

