



Cincinnati Public Schools

Emergency Medical Authorization Form

Please fill out the form below and return it to your school for their records.

Name _____ ID # _____ Hmrm. _____ Birth Date _____

School _____ Year _____

Student Name _____

Address _____ Apt. _____ Telephone () _____

City _____ State _____ Zip _____

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.

Residential Parent or Guardian

Mother's Name _____ Daytime Phone () _____

Father's Name _____ Daytime Phone () _____

Other's Name _____ Daytime Phone () _____

Name of Relative or Childcare Provider _____

Relationship _____ Daytime Phone () _____

Address _____ Zip _____

PART I or II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Physician _____ Phone () _____

Dentist _____ Phone () _____

Medical Specialist _____ Phone () _____

Local Hospital _____ Emergency Room Phone () _____

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 my 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 my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

Date _____ Signature of Parent/Guardian _____

Address _____ Zip _____

PART II: REFUSAL TO GRANT 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 to take the following action:

Date _____ Signature of Parent/Guardian _____

Address _____ Zip _____