Cincinnati Public Schools

Emergency Medical Authorization Form

Please fill out this form and return it to your child's school.

Student's Name: _____ ID #: _____ Homeroom: _____ Birth Date: _____

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.: _____ Phone: (____) _____

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 Child-care 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: _____

Cincinnati Public Schools

Emergency Medical Authorization Card

Please fill out this form and return it to your child's school.

Student's Name: _____ ID #:_____ Homeroom: _____Birth Date: _____

Cincinnati Public Schools
EMERGENCY MEDICAL AUTHORIZATION FORM

School: _____ Grade: _____ Year: _____

Student's Address: _____ Apt.:_____ Phone: (___)_____

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: (___)_____

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Date: _____ **Signature of Parent/Guardian:** _____

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Date: _____ **Signature of Parent/Guardian:** _____

Address: _____ Zip: _____