BEXLEY CITY SCHOOL DISTRICT
348 South Cassingham Road, Bexley, Ohio 43209

EMERGENCY MEDICAL AUTHORIZATION FORM

This form must be completed for each student year. Athletic medical participation forms will be required.

Student _____ (Last Name) _____ (First Name) _____ (Middle Name) _____ (Birthdate) School _____

Address _____

Home Phone _____ Grade _____

MEDICAL ALERT FOR SCHOOL OR CONSULTING PHYSICIAN

ALLERGIES TYPE: _____ Epi pen needed ☐ No ☐ **Yes** (***Allergy Emergency Action Plan Required***)
ASTHMA - COMMENTS: _____ Inhaler needed ☐ No ☐ **Yes** (***Asthma Action Plan Required***)
MEDICATIONS: _____
HEALTH CONCERNS: _____ **DIETARY CONCERNS:** _____

In the event of a medical emergency during school events, school personnel will attempt to contact the adults noted below in the order given. These adults should be able to pick up an ill student from school. A copy of this form is kept in the school clinic and accompanies students on field trips.

LEGALLY RESPONSIBLE ADULTS AND OTHER EMERGENCY CONTACTS (please list in contact preference order):

1. Contact One _____ Relationship to Student _____
   Daytime Phone _____ Cell Phone _____ E-mail _____
2. Contact Two _____ Relationship to Student _____
   Daytime Phone _____ Cell Phone _____ E-mail _____
3. Contact Three _____ Relationship to Student _____
   Daytime Phone _____ Cell Phone _____ E-mail _____

PART I or PART II - Must Be Completed

The purpose of this section: When legally responsible adults cannot be reached, please indicate below the authorization of emergency treatment for child who becomes ill or injured while under school authority.

PART I: REFUSAL OF CONSENT

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

_____

_____

Part I Signature of Legally Responsible Adult _____ Date _____

PART II: TO GRANT CONSENT

In the event reasonable attempts to contact the above named responsible adult(s) have been unsuccessful, I hereby give my consent for: 1) administration of any treatment deemed necessary by named practitioners or, in the event the designated preferred practitioner is not available, by another licensed practitioner; 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 practitioners concur in the necessity for such surgery and are obtained prior to the performance of such surgery. Signing this form authorizes employees of the Bexley City School District to share this information on a need-to-know basis.

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

Part II Signature of Legally Responsible Adult _____ Date _____

For more information - bexleyschools.org/health

Rev. 03/2014