



Our Lady of the Elms School

EMERGENCY MEDICAL AUTHORIZATION

2023-2024

To be completed by PARENT/GUARDIAN - Please Print using blue or black pen ONLY

Student

Last Name First Name Birth Date Grade in 23-24

Address

Street City State Zip

Contacts

Mother/Guardian Name Cell Phone Home Phone Work Phone

Email Personal Email Work

Father/Guardian Name Cell Phone Home Phone Work Phone

Email Personal Email Work

Other Person to Contact if Parent/Guardian is unavailable:

Name and Relationship to Student Contact Phone

Is this a new address or phone number? Yes No (please circle)

FACTS CONCERNING THE STUDENT'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED

Please Note: To insure the student's safety, information noted here may be shared with Our Lady of the Elms faculty or staff.

Allergies:

Any other medical information you feel the school should be aware of:

Medications Taken Regularly:

Uses Asthma Inhaler:

Uses Epi-Pen:

Date of Last Tetanus Shot:

PLEASE SEE BACK SIDE OF THIS FORM. YOUR SIGNATURE IS REQUIRED ON PAGE 2

The following is REQUIRED BY SECTION 3313.712 of the OHIO REVISED CODE.

**EMERGENCY MEDICAL AUTHORIZATION:** Enables parents a 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.

**PART I - TO GRANT CONSENT**

In the event that reasonable attempts to contact a parent/guardian at the above noted phone numbers have been unsuccessful, I HEREBY GIVE MY CONSENT FOR:

1. the administration of any treatment deemed necessary by:

Dr. \_\_\_\_\_ [Physician] at \_\_\_\_\_ [Phone]

Dr. \_\_\_\_\_ [Dentist] at \_\_\_\_\_ [Phone]

or, in the event that the DESIGNATED preferred practitioner is not available, by another licensed physician or dentist.

-and-

2. the transfer of the child to \_\_\_\_\_ [Hospital]  
or 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 the surgery.

Signed: \_\_\_\_\_  
[Parent/Guardian Signature Required] [Date]

**Do not complete Part II if you completed Part I**

**PART II - REFUSAL OF CONSENT**

I do NOT give my consent for emergency medical treatment of my child in the event of illness or injury requiring emergency care. I wish the School to take no action or to:

Signed: \_\_\_\_\_  
[Parent/Guardian Signature Required] [Date]