

**BERLIN-MILAN LOCAL SCHOOLS  
EMERGENCY MEDICAL AUTHORIZATION**

**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. **IF CHANGES OCCUR DURING THE SCHOOL YEAR, PLEASE CONTACT THE SCHOOL TO UPDATE!**

Student's Name \_\_\_\_\_ School \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

**Residential Parent or Guardian**

Father/Legal Guardian \_\_\_\_\_ Mother/Legal Guardian \_\_\_\_\_

Usual Work Shift \_\_\_\_\_ Usual Work Shift \_\_\_\_\_

Place of Employment \_\_\_\_\_ Place of Employment \_\_\_\_\_

Occupation: \_\_\_\_\_ Occupation \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (Home) \_\_\_\_\_

Phone (Work) \_\_\_\_\_ Phone (Work) \_\_\_\_\_

Cell phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

Name of Stepparent, Relative, Childcare Provider, or other (if parent/guardian cannot be reached). **\*REQUIRED**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (Daytime) \_\_\_\_\_

(Street, City, State, Zip)

Name of Another Contact (in case of illness not requiring emergency treatment but home care). **\*REQUIRED**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (Daytime) \_\_\_\_\_

(Street, City, State, Zip)

**PART I - TO GRANT CONSENT (Cont.)**

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 below named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; 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 physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

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

Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

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

Medical Concerns: \_\_\_\_\_

Regular Medications \_\_\_\_\_

Allergies & Treatment \_\_\_\_\_

Does your child have a documented disability that substantially limits a major life function (i.e. walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself and performing manual tasks)?  YES  NO

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Street, City, State, Zip)

**PLEASE DO NOT COMPLETE PART II IF YOU COMPLETED PART I**

**PART II - REFUSAL TO 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 authorities to take the following action:

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\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Street, City, State, Zip)

**PART I - EMERGENCY MEDICAL AUTHORIZATION (O.R.C. 3313.712)**

(A) Annually the board of education of each city, exempted village, local and joint vocational school district shall, before the first day of October, provide to the parent or legal guardian of every pupil enrolled in schools under the board’s jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent or legal guardian, either as part of any registration form which is in use in the district or as a separate form, an identical copy of the form contained in division (B) of this section.

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 his parent or legal guardian, authorities of the school in which the pupil is enrolled may permit the parent or legal guardian to make changes in a previously filed form, or to file a new form.

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

Even if a parent or legal guardian 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 extra-curricular activity authorized by the appropriate school authorities, the authorities of his school shall make reasonable attempts to contact the parent or legal guardian before treatment is given. The school shall present the pupil’s emergency medical authorization form or copy thereof to the hospital or practitioner rendering treatment.

Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. This form may be viewed or shared with other individuals who assume supervision or responsibility for your child while in school or at school-sponsored activities.

The emergency medical authorization form provided for in division (A) of this section is as follows: (See reverse side.)

**SCHOOL MEDICATION POLICY**

Students requiring medication are encouraged to receive the medication at home, if possible. Parents and Physician must complete a “request for administration of medication form for prescription as well as non-prescription medications (Tylenol, Motrin, etc.) **MEDICATION MUST COME TO SCHOOL IN THE ORIGINAL CONTAINER WITH THE AFFIXED LABEL FROM THE PHARMACY. THE LABEL MUST SHOW THE STUDENT’S NAME, THE NAME OF THE MEDICATION, THE DOSAGE DIRECTIONS, THE LICENSED PRESCRIBER’S NAME AND THE RX NUMBER (IF THERE IS ONE). TO BE COMPLETED BY THE PARENT/GUARDIAN**

I give my permission for the principal or his/her designee to administer the medication as prescribed above to my child and further agree to the following:

1. Submit to school personnel a revised statement signed by the licensed prescriber of the above medication when any change in the original statement (order) occurs.
2. Submit to school personnel a written statement when medication, given on a daily or as needed basis, has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child’s health and treatment issues as they certain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child to comply with medication administration instructions.
5. Provide safe transportation of the medication to and from school.

