

Last Name (Student)	First Name (Student)	Middle (Student)	Grade
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EMERGENCY CONTACT INFORMATION: (required)

Parent/Guardian Last Name _____ Parent/Guardian First Name _____
 _____ Place of Employment _____ Work Phone _____
 _____ Home Phone _____ Cell Phone _____

AUTHORIZED TO PICK UP

Last Name First Name Relationship _____ Place of Employment _____ Work Phone _____ Home Phone _____
 _____ Cell Phone _____

AUTHORIZED TO PICK UP

Last Name First Name Relationship _____ Place of Employment _____ Work Phone _____ Home Phone _____
 _____ Cell Phone _____

AUTHORIZED TO PICK UP

Last Name First Name Relationship _____ Place of Employment _____ Work Phone _____ Home Phone _____
 _____ Cell Phone _____

AUTHORIZED TO PICK UP

Last Name First Name Relationship _____ Place of Employment _____ Work Phone _____ Home Phone _____
 _____ Cell Phone _____

PART I

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 the above-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. Any hospital or practitioner having access to the child's medical history needs the following information:

****PLEASE NOTE: Sandusky County EMS will transport to Memorial Hospital of Sandusky County--(If you would prefer another hospital, please specify below and understand the greater travel distance may require an ambulance).**

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

Hospital (if other than ProMedica-Memorial) _____ Phone _____
 Doctor _____ Phone _____
 Dentist Phone _____
 Vision Specialist Phone _____ Date of last tetanus shot _____

Allergies _____

Medication Being Taken _____

Physical impairments (heart, epilepsy, etc.) _____

Other pertinent facts to which physicians should be alerted: _____

PARENT/GUARDIAN SIGNATURE DATE

PART II

As stated in Section 3313.712 of Ohio Law, this section also requires that this form, which is a facsimile of the form included in section 3313.712 be used. The law provides that the emergency medical form must be on file by October 1 of the current school year or the student will not be permitted to participate in any school function or activity.

I DONOT 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:

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____