Emergency Medical Authorization Form

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

Student's Name:	ID #:	Hor	neroom: _	E	3irth Date:
School:	Grade: _		Year:		_
Student's Address:		Apt.:	:	_ Phone	ə: <u>(</u>
City: State:	Zip:				
Purpose — To enable parents and guardians to autho injured while under school authority, when parents or g		_	-	ment for	children who become ill or
Residential Parent or Guardian Parent / Guardian Name:	_		Daytime	Phone:	()
Parent / Guardian Name:			Daytime	Phone:	()
Other's Name:			Daytime	Phone:	()
Name of Relative or Child-care Provider:					
Relationship:			Daytime	Phone:	()
Address:					Zip:
PART I <u>or</u> PA	RT II MUST BE C	OMPL	.ETED		
PART I: TO GRANT CONSENT I hereby give cons	ent for following me	edical-ca	are provid	lers and	local hospital to be called:
Physician:			Pho	ne: <u>(</u>)
Dentist:			Pho	ne: <u>(</u>)
Medical Specialist:			Pho	ne: <u>(</u>)
Local Hospital:	Emerg	ency Ro	om Phor	ne: <u>(</u>)
In the event reasonable attempts to contact me have be any treatment deemed necessary by above-named doc available, by another licensed physician or dentist; and authorization does not cover major surgery unless the concurring in the necessity for such surgery, are obtain Facts concerning my child's medical history, including a which a physician should be alerted:	ctors, or, in the ever l (2) the transfer of r medical opinions of ned prior to the perfo	nt the demy child two oth	esignated to any ho er license e of such	preferre ospital re ed physic surgery.	d practitioner is not easonably accessible. This cians or dentists,
Date: Signature of Parent/Guard	ian:				
Address:					Zip:
PART II: REFUSAL TO GRANT CONSENT I do NO event of illness or injury requiring emergency treatment			-		<u>-</u>
Date: Signature of Parent/Guardian:					
Address:					Zip:

Revised: 6/2019

Cincinnati Public Schools

Emergency Medical Authorization Card

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

Revised: 6/2019

Student's Name:	ID #:	Homeroom:Birth Date:
EMERGEN	Cincinnati Public Sch	
School:		Grade: Year:
		Apt.: Phone: ()
City:		
Purpose – To enable parents and guard who become ill or injured while under so		ovision of emergency treatment for children rents or guardians cannot be reached.
Residential Parent or Guardian		
Parent / Guardian Name:		Daytime Phone: ()
Parent / Guardian Name:		Daytime Phone: ()
i		Daytime Phone: ()
Name of Relative or Child-care Provider	:	
Relationship:		Daytime Phone: ()
Address:		Zip:
PART I	or PART II MUST BE	COMPLETED
PART I: TO GRANT CONSENT I hospital to be called:	hereby give consent for	the following medical-care providers and local
Physician:		Phone: ()
1		Phone: ()
1		Phone: ()
		mergency Room Phone: ()
administration of any treatment deemed preferred practitioner is not available, by	necessary by above-na y another licensed physic his authorization does n s or dentists, concurring	accessful, I hereby give my consent for (1) the timed doctors, or, in the event the designated cian or dentist; and (2) the transfer of my child not cover major surgery unless the medical gin the necessity for such surgery, are
		rgies, medications being taken, and any d:
Date: Signature of Pare	nt/Guardian:	
Address:		Zip:
PART II: REFUSAL TO GRANT C treatment of my child. In the event of illn the following action:	ess or injury requiring e	mergency treatment, I wish the school to take
Date: Signature of Page		
_		Zip:
Address.		