

STUDENT _____ TEACHER _____ GRADE _____
Last First

ADDRESS _____ UNIT / APT. _____ CITY _____

HOME PHONE _____ BIRTH DATE _____

MOTHER (GUARDIAN) _____ FATHER(GUARDIAN) _____

ADDRESS _____ ADDRESS _____

HOME PHONE _____ HOME PHONE _____

PLACE OF WORK _____ PLACE OF WORK _____

HOURS _____ PHONE _____ HOURS _____ PHONE _____

CELLULAR PHONE _____ CELLULAR PHONE _____

E-MAIL ADDRESS _____ E-MAIL ADDRESS _____

CHILD CARE PROVIDER _____ PHONE _____

IF PARENTS CANNOT BE REACHED, PLEASE NAME OTHER PEOPLE WHOM WE MAY CALL DURING SCHOOL HOURS.
PLEASE GET PERMISSION FROM EMERGENCY CONTACTS AND LIST IN ORDER OF PRIORITY.

	NAME	ADDRESS	PHONE	RELATIONSHIP
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

PART I (OR PART II - ON BACK OF SHEET) MUST BE COMPLETED

PART I - TO GRANT PERMISSION:
In the event reasonable attempts to contact me have been unsuccessful, I give 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 my child to any hospital reasonably accessible. I give consent to release medical information to the providers or the above listed contacts to assist in the care or treatment of my child. I also allow release of medical information to the educational staff having direct contact with my child UNLESS I notify the school in writing otherwise.

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 each surgery.

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

Name of Physician or Clinic _____ Address _____ Phone _____

Name of Dentist or Clinic _____ Address _____ Phone _____

Name of Medical Specialist _____ Address _____ Phone _____

Local Hospital _____ Address _____ Phone _____

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY, including allergies, medications being taken, and any physical impairments to which a physician should be alerted. IF NONE, WRITE NONE in spaces. **IF YOU HAVE A MAJOR HEALTH CONCERN, PLEASE CONTACT THE SCHOOL NURSE AT THE START OF SCHOOL.**

MEDICAL CONCERNS _____
REGULAR MEDICATIONS _____
ALLERGIES & TREATMENT _____

Date _____

*Signature of Parent/Guardian _____

IF NOT GIVING CONSENT, SIGN BACK OF

PART II - REFUSAL TO GRANT PERMISSION:

I do **NOT** give my consent for emergency medical treatment of my child _____ .
Name of Child

In the event of an illness or injury which requires emergency medical or dental treatment, I wish the school authorities to take the following actions:_____

_____ Date _____ *Signature of Parent/Guardian

SCHOOL MEDICATION POLICY

It is the policy of the Huron City Schools that all children’s medication be administered by a parent at home. Under exceptional circumstances medication may be administered by personnel providing the following state (Section 3313.713 of the Ohio Revised Code) and local regulations are met:

PARENTS AND PHYSICIAN MUST COMPLETE A “REQUEST FOR THE ADMINISTRATION OF MEDICATION“ FORM FOR PRESCRIPTION AS WELL AS NON-PRESCRIPTION MEDICATIONS (TYLENOL, ADVIL, ETC.). Forms are available at school and many health care provider’s offices. Remember to ask for a written order if the medication will be required during school hours BEFORE you leave the doctor’s office.

All medicine must be brought to the school office in the container in which it was dispensed or purchased and be clearly labeled with student’s name. It will be the student’s responsibility to come to the office for the medication at the appropriate time.

EMERGENCY MEDICAL AUTHORIZATION

ORC 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 medial 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.

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