NORTHWEST LOCAL SCHOOL DISTRICT Scioto County, McDermott, Ohio

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: ***To enable parents/guardians to authorize the provision of emergency treatment for their child who becomes ill or is injured while under authority of the Northwest Local School District when a parent/guardian cannot be reached.***

BUILDING: ❑ Elementary School (PS-5) ❑ Middle School (6-8) ❑ High School (9-12) ❑ Other:

GRADE: ❑ PS ❑ K ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12

TEACHER/HOMEROOM:

STUDENT NAME:	**Date Of Birth:**
Address:	**Telephone:**

RESIDENTIAL (CUSTODIAL) PARENT(S)/GUARDIAN(S):

Mother:	**Daytime Phone:**	**Cell Phone:**
Father:	**Daytime Phone:**	**Cell Phone:**
Other:	**Daytime Phone:**	**Cell Phone:**
Name of Relative or Childcare Provider:		**Relationship:**
Address:	**Daytime Phone:**	**Cell Phone:**

I hereby give consent for the following medical care provider(s) and/or local hospital to be called:

Doctor:	**Telephone:**
Dentist:	**Telephone:**
Medical Specialist:	**Telephone**
Local Hospital:	**Telephone:**

⮚⮚⮚⮚⮚ PART I or PART II MUST BE COMPLETED ⮘⮘⮘⮘⮘

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me at telephone #'s above or other parent/guardian at telephone #'s above have been unsuccessful, I/we hereby give my/our consent for: (1) the administration of any treatment deemed necessary by preferred physician, Dr. ________________ , or preferred dentist, Dr. ________________ , *OR*, in the event the preferred physician/dentist is not available, I/We give my/our consent for my/our child to be treated by another licensed physician or dentist; *AND* (2) I/We give my/our consent for my/our child to be transferred to local hospital,____________________________________, or any other hospital reasonably accessible. *This authorization does not cover major surgery unless the medical opinion of two (2) other licensed physicians or dentists concur regarding the necessity for such surgery.*

Please list any facts concerning your child's medical history ***(including, but not limited to: allergies, medications being taken, and any physical impairments)*** **to which a physician should be alerted before treatment is determined:**

◆ ***I understand that for my/our child's protection, any potential life threatening condition will be shared with appropriate school personnel with a need to know.***

☒ **SIGNATURE OF PARENT/GUARDIAN:**	**Date:**
☒ **SIGNATURE OF PARENT/GUARDIAN:**	**Date:**
Address:	

PART II: REFUSAL TO CONSENT ***[DO NOT COMPLETE if you completed PART I]***

I/We *DO NOT* give my/our permission for emergency medical treatment for my/our child. In the event of illness or injury requiring emergency treatment, I /We wish the school authorities to: *[Please check one]*

❑ ***TAKE NO ACTION.*** ❑ ***DO THE FOLLOWING***: *(Please be specific with your instructions.)*

☒ **SIGNATURE OF PARENT/GUARDIAN:**	**Date:**
☒ **SIGNATURE OF PARENT/GUARDIAN:**	**Date:**
Address:	

◆◆

Please list any additional persons to whom the school may release your child. ***PLEASE NOTE: It is your responsibility to notify the school, in writing, if any information provided on this form changes.***

Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**

Please complete reverse side of this page →

PART III: CONNECTIVITY AND DEVICE ACCESS

1. Do you have internet access from home? *(If no, you do not need to answer questions 2 and 3)*

❑ ***YES*** ❑ ***NO***

2. If yes, is your internet provided through cable, DSL or other?

❑ ***YES*** ❑ ***NO***

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➢➢ ***OR*** ➢➢

3. If yes, is your internet provided through a cellular hotspot or phone?

❑ ***YES*** ❑ ***NO***

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