EMERGENCY MEDICAL AUTHORIZATION
GROVE CITY HIGH SCHOOL BAND

School Year 2024 / 2025
Ohio Revised Code 3313.712

Student Name _____ Address _____

Date of Birth _____ _____

Grade _____ Telephone _____

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.

Residential Parent(s) or Guardian

Mother's Name_____ Phone:Home_____ Work_____ Cell_____

Father's Name _____ Phone:Home_____ Work_____ Cell_____

Other's Name (Guardian)_____ Phone:Home_____ Work_____ Cell_____

Name of Relative or Childcare Provider_____

Relationship _____ Address _____

Phone _____ _____

EITHER PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor _____ Office Phone _____

Dentist _____ Office Phone _____

Medical Specialist _____ Office Phone _____

Hospital _____ E.R. Phone _____

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 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.

See reverse side for facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted.

Signature of Parent/Guardian _____

Date _____

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:

Signature of Parent/Guardian _____

Date _____

MEDICAL INFORMATION

Allergies (including medications, foods, or environmental) _____

_____

_____

_____

Medications taken at least once a month (including over-the-counter and prescription)

Name of Drug	Dosage	How Often	Reason for Drug
1.			
2.			
3.			
4.			

(Attach an additional sheet of more medications are taken)

Facts concerning the child's medical history and any physical impairment to which a physician should be alerted:

_____

_____

_____

The following over-the-counter medications may be available to your student if needed, is he/she chooses to take them. Please check whether or not your student may take each drug.

MEDICATION	COMMON REASON FOR GIVING	ALLOWED TO TAKE	MAY NOT TAKE
Acetaminophen (Tylenol)	Mild pain, headache	☐	☐
Ibuprofen (Motrin, Advil, or Aleve)	Mild pain, inflammation, muscle pain, swelling	☐	☐
Benadryl & Antihistamines	Itching and swelling with insect bites, congestion with colds	☐	☐
Sudafed	Congestion	☐	☐
Immodium	Diarrhea	☐	☐
Mylanta, Maalox, Tums, & Pepcid AC	Upset stomach, hearthburn	☐	☐
Cough syrup & Guaifensin	Coughing	☐	☐
Dramamine	Motion illness	☐	☐

Nothing on this form shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with the provisions of this form or section 3313.712 of the Ohio Revised Code.

Please use the space below (or attach an extra sheet) if there is anything else we should know regarding your child's medical history or medications: