STUDENT NAME_____

(Please print) *Last* *First* *Middle Initial* *Date of Birth*

St. Charles Borromeo School * 4600 Ackerman Blvd * Kettering, OH * 45429 * 937-434-4933 * Fax 937-434-6692

EMERGENCY MEDICAL AUTHORIZATION and TRANSPORT AUTHORIZATION FORM

(Ohio Revised Code 3313.712 and 3301-37-08. This is an ANNUAL state requirement)

Student Address_____City_____Zip_____

Home Phone_____ Grade_____Teacher_____

Child Lives With (circle one) Mother/Father, Mother only, Father only, other (explain) _____

Legal Guardian (first and last name) _____

Mother's Name_____Day/Work Phone_____Cell_____

Address (if different) _____Email_____

Father's Name_____Day/Work Phone_____Cell_____

Address (if different) _____Email_____

Emergency Contacts (if unable to contact parents) **/Authorized Release** (parent authorizes person to pick up student)

****Must list at least 2 in the event parents cannot be located - list 2 non parental contacts****

Mother authorized to pick up student? YES NO Father authorized to pick up student? YES NO

Name	Relationship	Home Phone	Day/Cell Phone	Address
1)				
2)				
3)				

Instructions – parent/guardian to complete & return to school within **10 days of receipt**. **COMPLETE PART I or PART II – NOT BOTH**

Purpose – to enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. This information will be shared, as necessary, with teachers, administrative staff, health personnel and other school personnel.

PART I: TO GRANT CONSENT

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

Doctor_____Phone_____

Address_____

Dentist_____Phone_____

Address_____

Medical Specialist_____Phone_____

Local Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1) administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Please go to the back side of this form – Annual Medical Update

STUDENT NAME_____**Male/Female (circle one)**

(Please print) ***Last*** ***First*** ***Middle Initial*** ***Gender***

ANNUAL MEDICAL UPDATE

Instructions – please complete the health questionnaire below regarding your child. It is EXTREMELY important that you provide any pertinent medical history or information about existing conditions that may affect your child at school. The information will be reviewed by the school nurse and shared with school personnel as necessary. Homeroom teachers will receive a copy of this form for events that occur off school property (field trips or other such events).

1. Does your child have any allergies (food, insects, medicine)? YES NO If yes, describe:

   _____

2. Will your child require medications at school? YES NO If yes, describe and complete Request for Dispensing Prescription/Nonprescription Medication at School found on Option-C File Library.

   _____

3. Will your child require a health care plan or emergency health plan at school? YES NO If yes, describe:

   _____

4. Please review the conditions below and circle YES or NO as it applies to your child.

Chronic health concern(s)	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Heart/cardiac disease	YES	NO
Seasonal allergies	YES	NO	Seizure disorder	YES	NO
Anaphylaxis	YES	NO	Cancer or history of cancer	YES	NO
Bleeding disorder(s)	YES	NO	Recent surgery, serious illness, disease	YES	NO
Fears/anxiety	YES	NO	ADHD/ADD	YES	NO
Vision concern(s)	YES	NO	Wear glasses or contacts (circle one if yes)	YES	NO
Hearing concern(s)	YES	NO	Wears hearing aid(s)	YES	NO
Speech delay	YES	NO	Learning delay/concerns	YES	NO
Use of walking device (crutches, wheel chair, walker)	YES	NO	Use of a prosthesis	YES	NO

If you answered YES to any of the questions above, please explain:_____

_____

_____

_____

_____

_____

If there are any other health related issues that you feel that the school needs to be made aware of, please explain:_____

_____

Signature of Parent/Guardian **Date**