This form MUST BE completed and signed before your student will receive their schedule.
NORTH OLMSTED CITY SCHOOLS EMERGENCY MEDICAL AUTHORIZATION
NORTH OLMSTED MIDDLE SCHOOL

Student Date of Birth_____ M/F_____

Name of Legal Guardian(s)_____

Name(s) of persons with whom the student resides_____

Permission to contact non-custodial parent(s)? ( ) YES ( ) NO

If YES, Name and phone number of non-custodial parent _____
(phone number)

Health Concerns (Asthma, Diabetes, ADHD, etc.) _____

Known Allergies_____ Current Medications_____
Significant health concern information may be shared confidentially with appropriate school personnel to ensure the student's health and safety.

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority. LIST ONLY THE NAMES OF THOSE WHO HAVE AUTHORITY TO MAKE DECISIONS IN AN EMERGENCY SITUATION INVOVING THIS STUDENT. THEN INDICATE ON THE LINE TO THE LEFT THE ORDER IN WHICH YOU DESIRE CONTACT ATTEMPTS BE MADE BASED ON AVAILABILITY (i.e., 1ST, 2ND). PLEASE LIST TWO ALTERNATE CONTACTS.

_____Mother_____ Home#_____ Cell#_____

Place of Employment_____ Work#_____

_____Father_____ Home#_____ Cell#_____

Place of Employment_____ Work#_____

_____Stepparent_____ Home#_____ Cell#_____

Place of Employment_____ Work#_____

_____*Alternate_____ Home#_____ Work#_____
(Relationship to Student)

_____*Alternate_____ Home#_____ Work#_____
(Relationship to Student)

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of treatment deemed necessary by the preferred doctor indicated, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to the preferred hospital indicated, or, to the closest accessible hospital, if necessary. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Part 1 OR Part 2 MUST BE COMPLETED

Part1: I hereby consent for the following medical care providers to be called:

Preferred Physician_____

Phone#_____

Preferred Dentist_____

Phone#_____

Preferred Hospital_____

Parent Signature_____

Date_____

Part 2: I do NOT give my consent for emergency treatment of my child. In the event of illness or injury I would like the school to take the following action:

_____

_____

_____

_____

_____

Parent Signature_____

Date_____

(clh 12/9/09)

Student's Last Name_____ Student's First Name_____ Grade____

Home Address_____ Contact Phone #_____ this is Home__ or Cell__

___(Check here if address or phone number changed from last school year) Parent e-mail address to receive the principal's messages by email_____