

**PORTAGE LAKES CAREER CENTER  
EMERGENCY MEDICAL AUTHORIZATION**

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children whom become ill or injured while under school authority, when parents or guardians cannot be reached.

Student \_\_\_\_\_ Home Telephone No. \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
\_\_\_\_\_ Home School \_\_\_\_\_  
City & Zip \_\_\_\_\_ Program \_\_\_\_\_  
Parent E-mail Address \_\_\_\_\_ Grade \_\_\_\_\_

\*\*\*\*\*  
Residential Parent or Guardian  
Mother \_\_\_\_\_ Day/Work/Cell Phone# \_\_\_\_\_  
Father \_\_\_\_\_ Day/Work/Cell Phone# \_\_\_\_\_  
Other Name \_\_\_\_\_ Day/WorkCell Phone# \_\_\_\_\_  
Name of Another Relative or Childcare Provider \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ Relationship \_\_\_\_\_  
\*\*\*\*\*

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

Doctor \_\_\_\_\_ Phone# \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone# \_\_\_\_\_  
Med. Specialist \_\_\_\_\_ Phone# \_\_\_\_\_  
Hospital \_\_\_\_\_ Phone# \_\_\_\_\_

**Please Complete Part I or Part II – Not Both**

**PART I – TO GRANT CONSENT**

In the event the designated practitioner is not available, by another licensed physician or dentist; and (1) the administration of any treatment deemed necessary by the designated physician or dentist, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to the designated hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**Facts concerning the child’s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted (NOTE: To insure the student’s safety, information noted here may be shared with school faculty and staff.) *If a chronic health condition applies, please fill out the reverse side of this form:*** \_\_\_\_\_

Date \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_  
Address \_\_\_\_\_

**PART II – REFUSAL TO CONSENT (SIGN THIS SECTION ONLY IF REFUSING TO GRANT EMERGENCY MEDICAL ATTENTION.)**

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 no action or to: \_\_\_\_\_

Date \_\_\_\_\_ Parent or Guardian Signature \_\_\_\_\_  
Address \_\_\_\_\_

**PORTAGE LAKES CAREER CENTER  
ACTION PLAN FOR CHRONIC HEALTH CONDITION**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Program \_\_\_\_\_

Nature of Chronic Health Condition \_\_\_\_\_

Emergency Contact Information:

1<sup>st</sup> Contact

2<sup>nd</sup> Contact

Name \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

E-mail \_\_\_\_\_

E-mail \_\_\_\_\_

Preferred contact method \_\_\_\_\_

Preferred contact method \_\_\_\_\_

Emergency Protocol for Health Condition \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other considerations/protocols \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent Name (Please Print)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Name (Please Print)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

***\*Please fill out this form if a chronic health condition applies.***

## **Section 33.712, Ohio Revised Code**

### **(Pursuant to H.B. 639)**

- (A) Annually, the board of education of each city, exempted village, local and joint vocational school district shall, before the first day of October, have provided 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 the public school in this state for the first time, provide the parent or legal guardian of such pupil, either as part of any registration 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/her parent or guardian, authorities of the school in which the pupil is enrolled may permit such parent or guardian to make changes in a previously filed form, or to file a new form.

If a parent or guardian does not wish to give such written permission, he/she shall indicate in the proper place on the form the procedure he/she wishes school authorities to follow in the event of a medical emergency involving a child.

Even if a parent or guardian gives written consent for emergency medical treatment, when a pupil becomes ill or is injured and requires emergency medical treatment while under school authority, or while engaged in an extracurricular activity authorized by the appropriate school authorities of the school in which the pupil is enrolled shall make reasonable attempts to contact the parent or legal guardian before the treatment is given. The school shall present the pupil's emergency medical authorization form or a 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 attached.)