

EDGEWOOD CITY SCHOOLS  
EMERGENCY MEDICAL FORM O.R.C.3313.713

Grade _____
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Student Name: \_\_\_\_\_ School Bldg: \_\_\_\_\_ H.R.: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Birth date: \_\_\_\_\_

**PART I - Residential Parent/Guardian Information: Identify the names of the adults that we should contact to release your child to if your child becomes ill at school or needs to be picked up for any reason.**

Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mother's Email Address: \_\_\_\_\_ Father's Email Address: \_\_\_\_\_

Step-parent's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Other's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Relative or Child Care Provider: \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please identify all brothers and sisters who attend Edgewood School District in the event of an emergency.**

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**PART II - TO GRANT CONSENT:**

**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.

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Local Hospital: \_\_\_\_\_ 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 name 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 (2) other licensed physicians or dentists, 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 taken, and any physical impairments to which a physician should be alerted:

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

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**PART III – REFUSAL TO CONSENT:** I do NOT give 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 actions:

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Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

**WHITE – Principal**

**YELLOW – Nurse**

**PINK – Transportation**

Revised 07-08