2017 OHIO STATE SCHOOL FOR THE BLIND
EMERGENCY TREATMENT/ MEDICAL FORM A-1

Name:	
DOB:	
SS#:	
Parent/Guardian:	
Home Address:	
Cell Phone:	
Work Phone:	
Emergency Phone Contact:	
Last Tetanus:	
Allergies:	
Family Doctor:	
Eye Doctor:	
Eye Condition:	
Medicaid # (Send Copy):	
Insurance # (Send Copy):	

Part I—Please check one box for each item

1. Medical Treatment

☐ I authorize the provision of medical treatment for my child by a **school nurse and/or school physician** when my child becomes ill or injured while under school authority.

☐ I **do not give consent** and I wish the school authorities to take the following action:_____

_____

Signature:_____

2. Medication

☐ I hereby request and give my permission to the school nurse or his/her designee to administer medication to my child.

☐ I **do not request and do not give permission** to the school nurse or his/her designee to administer medication to my child and I wish the school authorities to take the following action:_____

_____

Signature:_____

Part II

Consent for Emergency Treatment:

In the event of an emergency and reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by the school physician; and 2) the transfer of my 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.

Date:_____ Signature:_____
(Parent or Guardian)

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 action:_____

_____

_____

Date:_____ Signature:_____
(Parent or Guardian)

Updates since last school year concerning the child's medical history including **allergies** any physical impairments the school nurse should be aware of:

_____

_____

_____

_____