**BUILDING**_____ **FREMONTCITYSCHOOLS DISTRICT**
**TEACHEREMERGENCYMEDICALAUTHORIZATION**

**2016-17**

| **Last Name***(Student)* | **First Name***(Student)* | **Middle***(Student)* | **Grade** |
|---|---|---|---|
| | | | |

**EMERGENCY CONTACT INFORMATION:** (*required)*

Parent/GuardianLast Name_____Parent/GuardianFirst Name_____

_____PlaceofEmployment_____WorkPhone_____

_____HomePhone_____CellPhone_____

☐**AUTHORIZED TO PICK UP**

Last NameFirstNameRelationship_____PlaceofEmployment_____WorkPhone___HomePhone_____

_____CellPhone_____

☐**AUTHORIZED TO PICK UP**

Last NameFirstNameRelationship_____PlaceofEmployment_____WorkPhone___HomePhone_____

_____Cell Phone_____

☐**AUTHORIZED TO PICK UP**

Last NameFirstNameRelationship_____PlaceofEmployment_____WorkPhone___HomePhone_____

_____CellPhone_____

☐**AUTHORIZED TO PICK UP**

Last NameFirstNameRelationship_____PlaceofEmployment_____WorkPhone___HomePhone_____

_____CellPhone_____

**PART I**

**Intheeventreasonableattemptstocontactmehavebeenunsuccessful,Iherebygivemyconsentfor(1)theadministrationofanytreatment deemednecessarybytheabove-nameddoctor,orintheeventthedesignatedpreferredpractitionerisnotavailable,byanotherlicensedphysician ordentist;and(2)thetransferofthechildtoanyhospitalreasonablyaccessible.Thisauthorizationdoesnotcovermajorsurgeryunlessthe medicalopinionsof twootherlicensedphysiciansordentists,concurringinthenecessityforsuchsurgery,areobtainedpriortotheperformanceof suchsurgery. Anyhospital orpractitionernothaving access tothechild'smedical historyneeds thefollowinginformation:**

****PLEASE NOTE: SanduskyCountyEMSwill transport toMemorial Hospital of SanduskyCounty–(If youwould preferanotherhospital, please specifybelowandunderstandthegreatertravel distancemayrequireanambulance).**

**Iherebygiveconsentforthefollowingmedicalcareprovidersandlocalhospitaltobecalled:**

Hospital(ifother thanProMedica–Memorial)_____Phone_____

Doctor_____Phone_____

DentistPhone_____

VisionSpecialistPhone_____Dateoflasttetanusshot_____

_____

Allergies_____

MedicationBeingTaken_____

Physicalimpairments(heart,epilepsy,etc.)_____

Otherpertinentfactstowhichaphysicianshouldbealerted:_____

**PARENT/GUARDIAN SIGNATUREDATE**

**PARTII**

AsstatedinSection3313.712ofOhioLaw,thissectionalsorequiresthatthisform,whichisafacsimileoftheformincludedinsection3313.712beused.
Thelaw providesthattheemergencymedicalformmustbeonfileby October1of thecurrentschoolyearorthestudentwillnot bepermittedtoparticipate inanyschool functionor activity.

**I DONOT**givemy consent for emergencymedical treatment of my child. Inthe event ofillness or injuryrequiring emergencytreatment,I wishthe school authorities totakethefollowing action:

_____

_____

**PARENT/GUARDIAN SIGNATURE** _____ **DATE** _____