Nordonia Hills City Schools
Emergency Medical Authorization Form

Student Name _____ School Attending _____

Street Address _____ City _____ Zip Code _____ Telephone _____

RESIDENTIAL PARENT OR GUARDIAN:

Mother:_____ Phone:_____ Father:_____ Phone: _____

Other:_____ Phone:_____

IF PARENT OR GUARDIAN IS UNAVAILABLE, NAME OF RELATIVE OR DESIGNATED CHILDCARE PROVIDER TO CONTACT:

Name:_____ Street Address:_____

Relationship:_____ Phone:_____

**********MEDICAL ALERT INFORMATION**********

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician or the school should be alerted include:_____

_____

CONSENT

Please complete either PART 1 or Part 2 below. **REV2003pm(HB639) O.R.C.3313.712**

Part 1 – TO GRANT CONSENT

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

Doctor:_____ Phone:_____ Dentist:_____ Phone: _____

Specialist:_____ Phone:_____ 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-named 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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian_____ **Address:**_____

City:_____ **Phone:**_____ **Date:**_____

B. Cleveland Clinic Twinsburg is our nearest emergency room, and therefore, most emergencies would be transported to their facility. It is always possible after emergency treatment to make arrangements to transport your child to your own preferred hospital.

I hereby give my consent for emergency treatment of my child at the Cleveland Clinic Twinsburg.

Signature of Parent/Guardian_____ **Date:**_____

Part 2 – REFUSAL TO CONSENT

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 the following actions:

_____

_____

Signature of Parent/Guardian_____ **Address:**_____

City:_____ **Phone:**_____ **Date:**_____