LAKE COUNTY EXTENDED SCHOOL OPPORTUNITIES
EMERGENCY FORM

EMERGENCY MEDICAL CONTACTS AND TRANSPORTATION AUTHORIZATION
TO BE COMPLETED BY ADULT HAVING LEGAL AUTHORITY OVER THE STUDENT

Per Ohio Revised Code Section 3313.712, this form is being provided 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.

Student Name_________________________ Date of Birth______________ Home Phone__________________________
(Last) (First) (Area Code)
Parent Name(s) ____________________________________________________________

Address __________________________________________ City________________________ Zip Code_______________

In situations where the parent cannot be reached the student may be released to the following:

Name:_________________________ Relationship:_________________________ Daytime Phone:_________________________ Cell:_________________________

Name:_________________________ Relationship:_________________________ Daytime Phone:_________________________ Cell:_________________________

Name:_________________________ Relationship:_________________________ Daytime Phone:_________________________ Cell:_________________________

PART I - TO GRANT CONSENT

I hereby give my consent for the following medical care providers and local hospital/emergency room to be called:

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 the 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.

** Facts concerning the child’s medical history, including allergies, medications being taken and any physical impairment which a physician should be alerted:

__________________________________________________________

Signature of custodial/residential parent:_________________________ Date________________________

PART II - DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II - 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 action:_________________________

__________________________________________________________

Signature of custodial/residential parent:_________________________

Address:________________________________________ Date:________________________________

2019-2020 School Year