STUDENT NAME	Ⅎ		
(Please print)	Last	First	(ID #)

(Please print) Last

Northmont City Schools LATCHKEY EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

0.1.1	Date of Birth			Home Phone	
School_					
School Year		Grade		Zip	
school authority, when p	parents or guar acluding stude	rdians cannot be reached. This informat nurses, and other school personn	rmation will be shared, as necessar	who become ill or injured while under y, with teachers, bus drivers, administrative	
			Daytime Phone	Cell	
Father's Name			_ Daytime Phone	Cell	
Emergency 1			Daytime Phone	Cell	
Contacts: 2			Daytime Phone	Cell	
Please identify any	health cor	ncerns that school personne	l should be aware of:		
Allergies: No	o Yes_	Specify			
Epi-pen: No	o Yes_	If yes, Epi-pen Authorizati	on Form must be completed.		
Asthma: No	Yes_	If yes, Inhaler Authorizatio	on Form must be completed.		
Seizures: No	o Yes_	Emergency seizure medicat			
				ame of medications	
Diabetes No.	o Yes_	Emergency diabetic medica		ame of medications	
		DARTIAD II MI			
PART I: TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called: DoctorPhone DentistPhone Medical SpecialistPhone Local Hospital/Emergency Room Phone:		IANTIUNIIMI	JST BE COMPLETED		
I hereby give conser and local hospital to Doctor	nt for the fol be called:	NT lowing medical care providers Phone Phone Phone	PART II: REFUSAL TO C I do NOT give my consent for my child. In the event of illnown	or emergency medical treatment of ess or injury requiring emergency authorities to take the following	

STUDENT NAM	ſE		
(Please print)	Last	First	(ID #)

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		Name of medication, amount taken, how often	
Will your student take medication at school? No	Yes	_ If yes, Permission to Dispense Medication Form must be completed.	
Are there any other medical conditions that school personnel should be aware of?			
PART I OR II MUST BE COMPLETED			

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONS	ENT	PART II: REFUSAL TO CONSENT
I hereby give consent for the f	ollowing medical care provi-	ders
and local hospital to be called:		I do NOT give my consent for emergency medical treatment of
Doctor	Phone	my child. In the event of illness or injury requiring emergency
Dentist	Phone	treatment, I wish the school authorities to take the following
Medical Specialist	Phone	action:
Local Hospital/Emergency Roc	om Phone:	
In the event reasonable attempts to	contact me have been	_
unsuccessful, I hereby give my co	nsent for: 1) the administration	of
any treatment deemed necessary b	y above named doctors, or, in the	ne
event the designated practitioner is	not available, by another licen	sed
physician or dentist; and 2) the tra	nsfer of the child to any hospita	
reasonably accessible. This author	ization does not cover major	
surgery unless the medical opinion	s of two other licensed physicia	nns
or dentists, concurring in the neces	sity for such surgery, are obtain	ned
prior to the performance of such s	ırgery.	
Signature of Parent/Guardian	Date	Signature of Parent/Guardian Date

STUDENT NAME		

(Please print) Last First (ID#)

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Ohio Revised Code 3313.712)			

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospital to be called: Doctor Phone Dentist Phone Medical Specialist Phone Local Hospital/Emergency Room Phone:	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:
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 doctors, or, in the event the designated 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 Date	Signature of Parent/Guardian Date