STUDENT'S NAME(S)	DOB	GRADE	HOME PHONE

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

____
Street | City | Zip

____
Father's Name | Occupation | Business/Cell Phone

____
Mother's Name | Occupation | Business/Cell Phone

____
Emergency Name/Phone | Emergency Name/Phone

____
Medical Insurance Carrier | Policy Number

EMERGENCY MEDICAL AUTHORIZATION

Purpose – 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.

NOTE: Please use back of form for information regarding specific students.

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at __________________________ (primary phone number) or ___________________________________ (name of other parent or guardian)

at ____________________ (phone number) have been unsuccessful, I HEREBY GIVE MY CONSENT for (1) the administration of any

treatment deemed necessary by Dr. _____________________________ (primary physician) or Dr. ________________________________ (primary dentist), 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 ____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two 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 IMPAIRMENTS to which a physician should be alerted.

____

____

____
DATE | **SIGNATURE OF PARENT OR GUARDIAN**

DO NOT COMPLETE PART II IF YOU 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 NO ACTION OR TO:

____

____
DATE | **SIGNATURE OF PARENT OR GUARDIAN** | **ADDRESS**_________

(OVER)

GAHANNA CHRISTIAN ACADEMY

817 North Hamilton Road
Gahanna, OH 43230

MEDICAL PROCEDURE ACKNOWLEDGEMENT

I, ________________________________, parent of ________________________________
Print name of parent(s) Name of student(s)

____

acknowledge the following steps will be taken in the event of a medical emergency.

1. The nurse will be summoned to the location of the student immediately. If appropriate, any medications on file with the nurse will be brought to the student.
2. The parent(s)/guardian(s) will be notified of the situation.
3. If the nurse deems it necessary, the emergency squad will be called to further evaluate the student.
4. If the nurse is unavailable, the emergency squad will be called immediately.

________________________________ ______
PARENT SIGNATURE **DATE**