CINCINNATI CHRISTIAN SCHOOLS
Christ-Centered 21st Century Education

EMERGENCY MEDICAL AUTHORIZATION

Student name _____ Date of Birth _____ Grade _____ School Year _____

Address _____ City/Zip _____ Home Phone _____

Father/Guardian: _____ _____ _____
Name/Place of Employment | Work Phone | Cell Phone

Mother/Guardian: _____ _____ _____
Name/Place of Employment | Work Phone | Cell Phone

Medical Insurance carrier _____ Policy Number _____ Policy Holder _____

Ohio Revised Code #3313.71

MEDICAL INFORMATION

(Please do not list any information that you wish to remain confidential.
Any confidential information should be listed on an attached sheet only. Thank you.) Attached sheet? _____Yes _____No

Does your child have any current medical conditions? _____

Past medical, emotional or surgical conditions (i.e. frequent upper respiratory infections, depressions, or cardiac surgery)?

_____

Currently on daily medications? _____

Allergies: PLEASE LIST ALL ALLERGIES—including food, drugs, and/or environmental. Rank frequency, severity, and give details if emergency treatment may be required or if a physician should be alerted.

_____

_____

_____

Is there any other information that would be helpful to a health professional in case of an emergency?

_____

Person to call if parent cannot be reached: 1. _____
Name | Phone | Relationship

2. _____ 3. _____
Name | Phone | Relationship | Name | Phone | Relationship

Child may only be released to: 1._____ 2. _____ 3. _____
Name | Name | Name

Part I (To Grant Request)

In the event that I cannot be contacted, I hereby give consent for the administration of any treatment deemed necessary by preferred physician Dr. _____ PH# _____ or preferred Dentist Dr. _____ PH# _____ or in the event the designated preferred practitioner is not available, by another licensed physician or dentist. I also give consent to transfer my child to _____ (preferred hospital) or 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 before surgery is performed. If emergency transportation is needed, we agree our child may be transported by a privately owned car or by life squad at parent expense. _____ Yes _____ No

_____ _____
Parent Signature | Date

Part II. DO NOT COMPLETE PART II IF YOU COMPLETED PART I.

I do not give my consent for emergency medical treatment of my child. I wish the school to take no action or to _____

_____ Parent Signature _____

Rev. 7/2/15