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. **Please use Blue or Black ink.**

Student Name (first, last)________________________________ DOB__________________ Male _________ Female __________
Address ____ City _________________________ Zip _______________
Home Phone ___________________________ Cell Phone ____________________________ Program __________________________

Father's Name (first, last) ____ Cell Phone__________________
Address (if different from student) ______________________________________ Home Phone _________________
Email Address ____ Work Phone _________________
Step-Mother's Name (first, last) ____ Cell/Work __________________

Mother's Name (first, last) ____ Cell Phone__________________
Address (if different from student) ______________________________________ Home Phone _________________
Email Address ____ Work Phone _________________
Step-Father's Name (first, last) ____ Cell/Work __________________

Guardian's Name (first, last) ____ Cell Phone _________________
(if other than parents)
Email Address ____ Work Phone _________________

*If applicable, please indicate who has custody of the student. First and last name ____
** Please provide a copy of custody papers.

Person(s) who may be notified and to whom your child may be released if the school cannot reach you:
1.____ Relationship_____________________ Phone ________________________________
2.____ Relationship_____________________ Phone ________________________________
3.____ Relationship_____________________ Phone ________________________________

____ ________________________________
Signature of Parent/Legal Guardian Date

Health issues, including dietary concerns must be communicated directly to Butler Tech District Nurse, Roslyn Ginter (513) 645-8271 or ginterr@butlertech.org, by the parent or guardian.

Medical Problems/Allergies/Special Needs to which a physician should be alerted

☐ Diabetes	☐ Seizures	☐ Heart Condition	☐ Chronic Illnesses/Disorders
☐ Asthma	☐ Orthopedic	☐ Visually Impaired	☐ Daily Medications
☐ Surgeries	☐ Allergy	☐ Hearing Impaired	☐ Bleeding Disorders
			☐ Emotional Problems

Please Describe____
____
____

The Student Health Nurse may share health information with appropriate school personnel to aid in present and future educational decisions. ☐ **Agree** ☐ **Disagree**

Doctor to be called ____ **Phone:** ____________________

Dentist to be called ____ **Phone:** ____________________

Preferred local hospital ____ **Phone:** ____________________

Part 1-TO GRANT CONSENT **Please sign either Part 1 or Part 2 but not both**

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctor or in the event the designated preferred practitioner is not available by another licensed physical or dentist; and (2) the transfer of the child to any hospital reasonable accessible. This authorization does not cover major surgery unless the medical opinion of two other license physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

____ ________________________________
Signature of Parent/Legal Guardian Date

Part 2-TO REFUSE 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: ________________________________

____ ________________________________
Signature of Parent/Legal Guardian Date