Butler Tech

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_____Called Name_____
Address _____ City _____ Zip _____

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 _____

Home Phone _____Cell Phone _____Grade _____ Program _____
*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 at (513)645-8271 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 reasonably 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