EMERGENCY MEDICAL FORM

LUCAS LOCAL SCHOOL DISTRICT

84 LUCAS NORTH RD. LUCAS OHIO 44843

Print Form

Student SS # _____ Student name _____ Grade ____

Address _____ City/Zip _____ Age____

Home Phone # _____ Cell Phone # _____ Student's Birthdate_____

The purpose is to enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while under the authority of Lucas Local School District and the student's leagal parent/guardian can not be reached.

The only person(s) authorized to release a student from school, for any reason, is the student's legal parent/guardian. for legal reasons, grandparents,siblings, and the like who are not legal guardians may not be contacted to excuse a student from school.

Legal Parent or Guardian Contact Information

Mother's Name _____ Emergency Phone _____

Father's Name _____ Emergency Phone _____

Other's Name _____ Relationship _____ Emergency Phone _____

Other's Name _____ Relationship _____ Emergency Phone _____

Other's Name _____ Relationship _____ Emergency Phone _____

Name of student 's regular care provider_____

Address _____ Phone _____

Student's medical history, including allergies, prescribed medicines and physical impairment(s) to which a physician and the district should be alerted to in order to protect the student's health, safety and well being

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:

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Hospital of Choice _____ Emergency room Phone _____

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 doctor, or in the event the designated preferred practitioner is not available , by any other 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, dentist concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Date_____ Signature of Parent or Guardian _____

Address_____

PART II – REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the vent of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

_____

Date_____ Signature of Parent or Guardian _____

Address_____

Teacher _____

Student name _____

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