

# EMERGENCY MEDICAL FORM

Student's Grade: \_\_\_\_\_

**Crestview Local Schools**  
1575 State Route 96  
Ashland, Ohio 44805-9633  
419-895-1700

Student's Name: \_\_\_\_\_  
Student's Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_, \_\_\_\_\_, **OH** \_\_\_\_\_  
Phone Number: \_\_\_\_\_

*Purpose is 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.*

**Parent or Guardian** Please check ( ) which parent(s)/guardian your child resides with.

*For emergency purposes, please list in (1, 2, 3, 4) order of preference who is to be contacted:*

___ ( ) Mother's Name: _____	Daytime Phone (____) ____--_____
Address: _____	Cell Phone (____) ____--_____
___ ( ) Father's Name: _____	Daytime Phone (____) ____--_____
Address: _____	Cell Phone (____) ____--_____
___ ( ) Other's Name: _____	Daytime Phone (____) ____--_____
Address: _____	Cell Phone (____) ____--_____
___ Name of relative, family friend or child-care provider: _____	
Relationship to child: _____ Address: _____	Phone (____) ____--_____

**If your child is being treated for any of the following, please check.**

[ ] Diabetes [ ] Seizures [ ] Asthma [ ] Severe allergies to bee stings [ ] Migraines [ ] Food allergies (list below)

*Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician and school employees should be alerted to protect the student's health and safety.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 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: (____) ____--_____
Local Hospital: _____	Emergency Room (____) ____--_____

*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 another 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 or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.*

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

### 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 the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_