



PICKERINGTON LOCAL SCHOOL DISTRICT

777 Long Road, Pickerington, Ohio 43147
Phone: 614-833-2110 Fax: 614-833-2143
www.pickerington.k12.oh.us

EMERGENCY MEDICAL AUTHORIZATION

School: \_\_\_\_\_

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

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.

Table with 5 columns: Residential Parent or Guardian Information, Home Phone, Work Phone, Cell Phone, E-mail Address. Rows include Mother's Name, Father's Name, Alternate Contact Name, and Address/Relationship to child.

PART I OR PART II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medial care providers and local hospital to be called:

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_
Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_
Medical Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_
Local Hospital: \_\_\_\_\_ 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 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.
• Pertinent health information will be shared with appropriate school staff only on a need-to-know basis.
• Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted: \_\_\_\_\_

\_\_\_\_\_
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

PICKERINGTON NORTH MUSIC BOOSTERS – BAND  
EMERGENCY MEDICAL HISTORY

TO BE RETURNED FULLY COMPLETED BEFORE START OF BAND CAMP, DATE: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
City or Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work phone – Mother \_\_\_\_\_  
Father \_\_\_\_\_

IN CASE OF EMERGENCY NOTIFY: (IF GUARDIAN CANNOT BE REACHED)

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

HEALTH HISTORY

Have or subject to: (check if Yes)

\_\_\_\_\_ Asthma \_\_\_\_\_ Fainting Spells \_\_\_\_\_ Convulsions  
\_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Trouble \_\_\_\_\_ Other  
\_\_\_\_\_ Sport Restrictions \_\_\_\_\_ Food, Medication or Insect Bite Allergies (Note below)

Describe \_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK HERE IF NONE OF THE BELOW APPLIES \_\_\_\_\_

Have difficulty with:

\_\_\_\_\_ Eyes, Ears, Nose, Throat \_\_\_\_\_ Menstrual Problems \_\_\_\_\_ Measles  
\_\_\_\_\_ Lungs \_\_\_\_\_ Bed Wetting \_\_\_\_\_ Mumps  
\_\_\_\_\_ Digestion \_\_\_\_\_ Sleepwalking \_\_\_\_\_ Chicken Pox  
\_\_\_\_\_ Whooping Cough \_\_\_\_\_ German Measles \_\_\_\_\_ Diphtheria

Any conditional now requiring regular medication \_\_\_\_\_  
If yes, name and type \_\_\_\_\_

Any restrictions of activity for medical reasons? \_\_\_\_\_ Explain \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*If your daughter/son is allergic to latex please check \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_  
Name in which insurance is listed \_\_\_\_\_  
Group Number \_\_\_\_\_ Insurance Identification No. \_\_\_\_\_

Grades 7-12

1. Neither prescription nor non-prescription medication will be administered by school personnel or by chaperones to students in grades 7-12.
2. Students who must have medication are to bring only the dosage for that particular day and administer the medication by themselves.
3. Ace Bandages – only for those injured at camp or on a trip. If student has a known/chronic problem, student should bring own “wrap”.