Bexley Schools Emergency Medical Authorization

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians cannot be reached.

Student - First Name:_____ Last Name:_____ Grade:_____ Date of Birth: _____

Student ID:_____ Address:_____ Phone: _____

<<<<< MEDICAL ALERT FOR SCHOOL OR CONSULTING PHYSICIAN >>>>>

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which the school or a consulting physician should be alerted:

ALLERGIES TYPE:

Epi pen needed No / Yes (Allergy Emergency Action Plan Required)

ASTHMA - COMMENTS:

Inhaler needed No / Yes (Asthma Action Plan Required)

MEDICATIONS:

HEALTH CONCERNS:

DIETARY CONCERNS:

In the event of a medical emergency during school events, school personnel will attempt to contact the adults noted below in the order given. These adults should be able to pick up an ill student from school, a practice, or a game. A copy of this form is kept by the athletic trainer, coaching staff, nurses and staff who accompanies students on all trips.

LEGALLY RESPONSIBLE ADULTS AND OTHER EMERGENCY CONTACTS FOR MY SON/DAUGHTER ARE AS FOLLOWS:

1. (Person filling out form)

First Name: _____ Last Name: _____ Relationship to student: _____

Phone (D): _____ Phone (C): _____ Email: _____

2. (Other Adult)

First Name: _____ Last Name: _____ Relationship to student: _____

Phone (D): _____ Phone (C): _____ Email: _____

3. (Other Adult)

First Name: _____ Last Name: _____ Relationship to student: _____

Phone (D): _____ Phone (C): _____ Email: _____

PART I or PART II BELOW MUST BE COMPLETED

Purpose: When legally responsible adults cannot be reached, please indicate below the authorization of medical treatment for children who become ill or injured while under school authority.

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact the above named responsible adult(s) have been unsuccessful, I hereby DO GIVE my consent for: 1) administration of any treatment deemed necessary by named practitioners or, in the event the designated preferred practitioner is not available, by another licensed practitioner; 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 practitioners concur in the necessity for such surgery and are obtained prior to the performance of such surgery. Signing this form authorizes employees of the Bexley City School District to share this information on a need-to-know basis.

Physician:_____ Phone:_____

Dentist:_____ Phone:_____

Medical Specialist:_____ Phone:_____

Local Hospital:_____ Phone: _____

Signature Legally Responsible Adult:_____ Date: _____

PART II: REFUSAL OF CONSENT

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

_____

Signature of Legally Responsible Adult:_____ Date: _____

Are you a student athlete in a Middle or High School OHSAA program? No / Yes (complete next section)

SPORTS INSURANCE INFORMATION

The Bexley City School District requires that all athletes participating in extra-curricular sports be covered by health insurance. In place of, or in addition to, your current family health coverage, the district offers you the opportunity for the student to be covered by a supplemental policy from the N. Carol Insurance Company or Guarantee Trust Life Insurance Company. These programs are managed strictly through the companies; all applications and claims go directly through the provider, not the school district. These forms are available through the coaches of individual sports as well as the athletic office. Below, please check all that apply and sign:

My child is currently covered under family health insurance.
If yes, family insurance company name and policy number: _____

My child will be covered by the supplemental insurance offered by the N. Carol Agency or Guarantee Trust Life Insurance Company.
I certify that I have obtained the necessary forms and am sending the required premium fee directly to the provider.

Signature Parent/Guardian:_____ Date: _____