

# OTTAWA-GLANDORF SCHOOLS

**EMERGENCY MEDICAL  
AUTHORIZATION  
FORM 5341**

Rev 10-08

Student Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

Please check if this is a new address from previous school year.

Home Phone \_\_\_\_\_

Please check if this is a new number from previous school year.

E-Mail Address \_\_\_\_\_

Grade Level/Homeroom \_\_\_\_\_ School Year \_\_\_\_\_

**CONTACT INFORMATION**

Custodial Parent(s) \_\_\_\_\_

**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 number** in order of who should be called first, second and third.

			<i>Home</i>	<i>Work</i>	<i>Cell</i>	
_____	Mother's Name	Work Place	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Father's Name	Work Place	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Other's Name	Work Place	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Name of relative or childcare provider to be contacted in the event parents cannot be reached: (please list at least two)

			<i>Home</i>	<i>Work</i>	<i>Cell</i>	
_____	Name	Relationship	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Name	Relationship	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	Name	Relationship	Daytime Phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**LEGAL CUSTODY**

If this is a divorced and separated home, list below the Court Docket Number which gives the name of the person(s) having legal custody: (must have a copy on file)

Docket Number \_\_\_\_\_ State of \_\_\_\_\_ Copy on File: Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Docket \_\_\_\_\_ Person(s) having legal custody \_\_\_\_\_

If not living with person of legal custody, state name of person with whom child is living:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

**PERMISSION**

### FIELD TRIP PERMIT

\_\_\_\_\_ has my permission to go with a school chaperoned group on field trips away from the building.

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

### PUBLICITY PERMIT/CLASS ROSTER

The Ottawa-Glandorf Schools have permission to use my child's name and photograph in any school related news release to local and area newspapers and to make available, upon request student directory information.

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

**PART I OR II MUST BE COMPLETED**

I hereby give consent for the following medical care providers and local hospitals to be called:

_____ Doctor	_____ Phone
_____ Dentist	_____ Phone
_____ Optometrist	_____ Phone
_____ Medical Specialist (if needed)	_____ 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.

Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which the schools should be alerted:

**Allergies** (bee stings, foods, etc.) \_\_\_\_\_

**Medications Taken** \_\_\_\_\_

**Physical Impairments** \_\_\_\_\_

**Asthma** \_\_\_\_\_

**Seizures** \_\_\_\_\_

**Diabetes** \_\_\_\_\_

Names of other children in your family:

\_\_\_\_\_

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

PART I

**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 no action; or to: \_\_\_\_\_

\_\_\_\_\_

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

PART II

**ATHLETIC INSURANCE**

\_\_\_ My child does **not** plan to participate in any athletic program sponsored by Ottawa-Glandorf Schools.

\_\_\_ My child plans to participate in athletics sponsored by Ottawa-Glandorf Schools and has permission to participate in the following sport(s): \_\_\_\_\_

We understand that our child must be covered by insurance to participate. In the event of an injury, we will cover the medical expenses as follows:

\_\_\_ We have family insurance. \_\_\_ We have purchased the school insurance. \_\_\_ We have both family and school insurance.

We understand that we are responsible for all excess costs above and beyond what the insurance will not cover and that the school does not carry any insurance on student athletes. We also give permission for the school person in charge to determine when our child should be taken for emergency medical treatment. We have instructed our student athlete to report all injuries to the person in charge immediately.

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

ATHLETIC INSURANCE