

St. Andrew Preschool
Emergency Card

School Year _____ Student's Name _____

Class: 3 yr. olds___ 4 yr. olds___ PreK___

Birthdate _____

Address _____

_____ Zip Code _____

Phone Number _____

Father/Guardian's Name _____

Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone/Pager _____

Email Address _____

Place of Employment _____

Mother/Guardian's Name _____

Address _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone/Pager _____

Email Address _____

Place of Employment _____

In the event that this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1. _____ Relationship _____ Phone _____

2. _____ Relationship _____ Phone _____

3. _____ Relationship _____ Phone _____

EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

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.

PART I OR PART 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 _____
(Name) (Address) (Phone)

Dentist _____
(Name) (Address) (Phone)

Medical Specialist _____

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 doctors, 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 obtain prior to the performance of such surgery.

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

Date _____ Signature of Parent/Guardian _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 _____