Richmond Heights Local Schools

Learn, adapt, and excel in a changing world.

Emergency Medical Authorization

To enable parents and guardians to provide necessary information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority.

Student Name _____ _____
Last **First** **Middle** **Birth Date**

Home Address _____ Apt. _____

Primary Phone (_____) _____ E-mail _____

Parent(s) or Guardian with whom student lives:

_____ / _____
Name / Relation to student **Name / Relation to student**

Cell Phone (_____) _____ **Cell Phone** (_____) _____

Daytime (_____) _____ **Daytime** (_____) _____

Non-Residential Parent (If Applicable)

_____ (_____) _____
Name / Relationship to Student Primary Phone

_____ _____ _____ _____ _____
Address Apt. City State Zip Code

Is there a court order which limits / prohibits non-custodial parent contact? **O Yes** **O No**
If yes is marked, parent must contact the office and provide legal documentation.

Transportation

Bus # to school _____ Bus # from school _____ Car rider _____ Walk _____

* If your child does not go home after school, please list where the child goes, on what days, and phone number:

_____ (_____) _____ M T W TH F
Name / Agency Phone Number Circle Days

Note: Requests to change normal transportation MUST be made in writing.

List the person(s) who will care for your child in the event that reasonable attempts to contact parent(s) have been unsuccessful. List contacts in the order in which you prefer them to be called.

1. _____ (_____) _____
Name / Relationship to Student Primary Phone

2. _____ (_____) _____
Name / Relationship to Student Primary Phone

3. _____ (_____) _____
Name / Relationship to Student Primary Phone

Please include name of an older sibling who is authorized to pick up student in the event of a disaster.

_____ Grade _____

--- OVER ----

Information Concerning Student's Health – Please print

Medical History: _____

_____

Allergies (insect, food, medications, etc.): _____

_____

Physical impairments that limit mobility: _____

_____

Medications taken (including dosage and times given): _____

_____

****Please note: If your child would need to take any medication during a 24-hour period of "sheltering in place", please contact the school nurse to discuss this matter confidentially.**

Describe any **critical medical information** the bus driver should be aware of when transporting this student:

_____

_____

To Grant Consent

O **I grant consent,** in the event that reasonable attempts to contact me have been unsuccessful, (1) for the administration of any treatment deemed necessary by the named doctors:

Dr. _____ Phone Number (_____) _____
Preferred Physician

Dr. _____ Phone Number (_____) _____
Preferred Dentist

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

(2) the transfer of the child to (preferred hospital) _____, or 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.

_____ _____
Signature of Parent / Guardian Date

Refusal to Grant Consent

O **I refuse to grant consent** for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

_____

_____

_____ _____
Signature of Parent / Guardian Date

I understand that I am responsible for keeping ALL information current and correct.

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