Newton Falls Exempted Village Schools
www.newton-falls.k12.oh.us

909 ½ Milton Blvd., Newton Falls, OH 44444
Board of Education: 330-872-0862 Fax: 330-872-3351
Superintendent: Paul Woodard – Treasurer: Dawn Meeks

Emergency Medical Authorization Form

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.

STUDENT'S NAME LAST	FIRST	MIDDLE	BIRTHDATE	MALE	FEMALE
				☐	☐

ADDRESS

HOME PHONE	HOMEROOM TEACHER	STUDENT CELL PHONE	GRADE

MOTHER / GUARDIAN NAME	Child live with you?	DAYTIME PHONE

ADDRESS (Street, City, Zip)

MOTHER/GUARDIAN CELL PHONE	PLACE OF EMPLOYMENT	WORK PHONE

FATHER / GUARDIAN NAME	Child live with you?	DAYTIME PHONE

ADDRESS (Street, City, Zip)

FATHER/GUARDIAN CELL PHONE	PLACE OF EMPLOYMENT	WORK PHONE

MOTHER / GUARDIAN EMAIL FATHER / GUARDIAN EMAIL

PARENTS ARE (Check one) ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ NEVER MARRIED

IF PARENTS ARE DIVORCED, SEPARATED OR HAVE NEVER BEEN MARRIED, PLEASE COMPLETE THE FOLLOWING SECTION:

FULL NAME OF PERSON(S) WHO HAS CUSTODY OF CHILD RELATIONSHIP

ADDRESS	PHONE

PARENT/GUARDIAN(S) & EMERGENCY CONTACTS

Child will only be released to persons listed below. ***Be sure to include parents' and/or guardians' names.***
Emergency contacts should be prepared to show identification when picking up child.

Call Order:	Relationship:	Name:	Cell Phone:	Home Phone:	Can pick up:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Continued on other side

Newton Falls Exempted Village Schools **Emergency Medical Health Information**

Student Name: _____ Date: _____

My child has the following serious or chronic health condition(s):

List any allergies your child has _____

_____ *Asthma that requires medication or EMERGENCY treatment
_____ *Bee Sting Allergy that requires medications or EMERGENCY treatment
_____ *Severe allergy that requires medication or EMERGENCY treatment
_____ * Diabetes
_____ Activity limitation/restriction
_____ ADD or ADHD (circle)
_____ Hearing Disorder
_____ Vision Disorder
_____ Seizure Disorder
_____ Heart Condition
_____ Urinary Tract Disorder
_____ Muscular/Skeletal Disorder
_____ Respiratory Illness (other than Asthma)
_____ Other Serious or Chronic Conditions

Explain: _____

_____

If your child has any condition above with * denoted, contact the school nurse for the required medication and/or physician authorization forms.

Medications

List all prescribed medications taken on daily basis at home _____

List all prescribed medications that will be taken daily at school _____

Please refer to the student handbook for rules regarding medication at school. Please note that a new medication consent form must be completed **every year** (even if medication has not changed).

Parent(s) Names: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

I understand that this health information may be shared with school staff, on a need to know basis, maintaining student confidentiality and complying with privacy standards.

Parent/Guardian Signature: _____

Emergency Medical Authorization

******* You MUST complete Part I or Part II *******

Part I – TO GRANT CONSENT: I hereby give consent for the following medical care providers or hospitals to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hearby give my consent for: (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician of dentist, and (2) the transfer of the child to any hospital reasonable accessible.

Date: _____ Signature of Parent of Guardian _____

Address: _____

Part II – REFUSAL TO CONSENT: I do NOT give my consent for the 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 of Guardian _____

Address: _____