BLANCHESTER LOCAL SCHOOL DISTRICT
951 CHERRY STREET · BLANCHESTER, OHIO 45107
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www.blanschools.org

STUDENT EMERGENCY MEDICAL FORM

Date: _____ / _____ / _____ Grade: _____ Teacher: _____

Student: _____ D.O.B.: _____ / _____ / _____ ☐ Male ☐ Female

Address: _____ County: _____

_____ Home Phone: _____

_____ Cell Phone: _____

Parent(s) or Guardian(s)
Mother's Name: _____ Cell/Daytime Phone: _____

Father's Name: _____ Cell/Daytime Phone: _____

Lives with: _____ Cell/Daytime Phone: _____

Purpose: To enable parents and guardians to authorize emergency treatment for children who become ill or injured under school authority when parents or guardians cannot be reached. Please list at least two (2) persons you wish to be called.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

PART I and PART II MUST BE COMPLETED

PART 1 - TO GRANT CONSENT

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

Doctor's Name:	Phone #:
Dentist's Name:	Phone #:
Medical Specialist::	Phone #:
Local Hospital:	Phone #:

In the event of reasonable attempts to contact me have been unsuccessful, I hereby give 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. (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.

Medical Problems/Special Needs: ☐ Diabetes ☐ Asthma ☐ Seizures ☐ Heart Condition ☐Recent Surgery
☐ Physical Limitations ☐ Emotional Problems ☐ Mild Allergies ☐ Severe Allergies ☐ Other Conditions
Please describe any conditions marked above: _____

Current Medications: _____

Permission granted for school health screenings such as hearing, vision and/or scoliosis? ☐ Yes ☐ No
Note- Parent exemptions form screening mandated by Ohio law may require documentation from your doctor or optometrist.

Parent/Guardian: _____ _____ _____ / _____ / _____
Name Signature Date

PART II - REFUSAL TO CONSENT

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

Parent/Guardian: _____ _____ _____ / _____ / _____