Lordstown Local Schools
Emergency Medical Authorization

School Year ________________ Building: ________________________

Student

Last: ____________________ First: ____________________ Middle: ______________ Birthdate: __________

Street Address: ________________________________ City: ________________ State: _____ Zip: ________

Home Telephone: ________________ Grade: _____

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.

Residential Parent or Guardian

Mother's Name: ______________________ Daytime Phone: ______________ Cell Phone: ______________

Father's Name: ______________________ Daytime Phone: ______________ Cell Phone: ______________

Other's Name: ______________________ Daytime Phone: ______________ Cell Phone: ______________

Name of relative or childcare provider who will assume temporary care of your child if you cannot be reached

Name: ______________________ Relationship to child: ________________ Phone: ______________

Address: ____

Name: ______________________ Relationship to child: ________________ Phone: ______________

Address: ____

Part I or 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:

Doctor: ____ Phone: ______________________

Dentist: ____ Phone: ______________________

Medical Specialist: ______________________________ Phone: ______________________

Local Hospital: _________________________________ Emergency Room Phone: ______________

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: (check all that apply)

☐ Asthma ☐ Headaches ☐ Stomach/Digestive problems ☐ Seizure disorder ☐ Other ______________

☐ Diabetes ☐ Heart problems ☐ Orthopedic problems ☐ Allergies (specify) ______________________

Does your child have any known allergies to medications? ☐ YES ☐ NO If yes, what medication(s)? ______________

Medications taken regularly: ____

Date of last Tetanus shot: ________________

Is your child allergic to acetaminophen (Tylenol)? ☐ YES ☐ NO

Can designated LHS personnel administer Tylenol for headache or menstrual cramps? (**Grades 7 - 12 Only**) ☐ YES ☐ NO

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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. **If you do not wish to consent, please turn over and sign the back of this form.**

Date: __________________ Parent/Guardian Signature: ________________________________

Over

Part II - Refusal To Consent - Do NOT complete, if you completed Part I

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

Date: ______________________ Parent/Guardian Signature: ______________________________________