EMERGENCY MEDICAL AUTHORIZATION

Miami Valley Career Technology Center

Pursuant to Section 3313.72, Ohio Revised Code

Home School: Name:

MVCTC Program: Address:

DOB: Primary Phone:

RESIDENTIAL PARENT OR GUARDIAN (Please indicate if listing step-parents):

Mother's Name: Daytime Phone: Cell:

Father's Name: Daytime Phone: Cell:

Guardian's Name: Daytime Phone: Cell:

EMERGENCY CONTACTS (Staff will call in order listed, if parent/guardian CAN NOT be reached):

Name: Relationship: Phone:

Name: Relationship: Phone:

HEALTH INFORMATION (Medication forms are available from the clinic or MVCTC web site: www.mvctc.com/wellness):

Allergies: Specify:

Epi-Pen: Epi-Pen Medication Form must be completed and signed by a physician if student carries Epi-Pen.

Asthma: Asthma Inhaler Medication Form must be completed and signed by a physician if student carries inhaler.

Diabetes: Name(s) of Medications:

Indicate daily medications and/or health problems:

Administration of Over-The-Counter Medication

The Clinic in the West Building will keep a supply of generic acetaminophen, ibuprofen and Pepto Bismol. These are adult strength tablets.
I hereby request and grant permission for Miami Valley CTC to supervise the medication routine below for the above student. I understand that non-medical school personnel may supervise the administration of medication. This authorization will be in effect unless revoked in writing by the parent/guardian.

Yes / No ____ Acetaminophen (325 mg/tab) 2 tablets Yes / No ____ Ibuprofen (200 mg/tab) 2 tablets Yes / No ____ Pepto Bismuth (262 mg/tab) 2 chewables

PART I - TO GRANT CONSENT (PART I OR II MUST BE COMPLETED):

Doctor: Telephone:

Dentist: Telephone:

Preferred 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 emergency medical 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 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Custodial Parent Address of Custodial Parent Date

PART II - REFUSAL TO CONSENT - DO NOT COMPLETE IF YOU COMPETED PART I

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 no action; however, medical situations may be referred to appropriate medical personnel if deemed necessary:

Signature of Custodial Parent Address of Custodial Parent Date