Mac-A-Cheek Learning Center

1130 W. Sandusky Ave., Bellefontaine, OH 43311
Phone - 937-404-1263 Fax - 937-292-7035

EMERGENCY MEDICAL FORM

(Ohio Revised Code 3313.712)

COMPLETE BOTH SIDES OF FORM

Student's Name		**Date of Birth**
Student's Address	**City**	**Zip**

Responsible Adult Student Lives with (please Circle)

Mother & Father | Mother Only | Father Only | Mother & Step-Father | Father & Step-Mother | Foster Parent | Other: ____________________

PLEASE INDICATE PARENT(S), PERSON(S) OR GOVERNMENT AGENCY HAVING LEGAL OR PERMANENT CUSTODY OF THIS STUDENT
STUDENT'S GUARDIAN WILL BE CONTACTED FIRST. (PLEASE PROVIDE INFORMATION FOR BOTH PARENTS FOR THIS STUDENT)
(FOR STUDENTS IN FOSTER CARE PLEASE LIST THE AGENCY WHO HAS LEGAL CUSTODY AND FOSTER PARENTS)

Name(s)		**Relationship to Student**	
Home Address		**City**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	**Email**

Name(s)		**Relationship to Student**	
Home Address		**City**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	**Email**

Emergency Contacts - In the event we are unable to contact the student's guardian please list the first and last name of other persons who have authority to make decisions in an emergency situation involving this student. List in the order you desire contact attempts to be made based on availability. List the relationship of each contact to the student. (aunt, grandparent, friend, etc.). These contacts will also have permission to pick your child up from school.

Relationship to Student	Name	Home Phone	Work Phone	Cell Phone

COMPLETE ONLY ONE OF THE FOLLOWING: SECTION I - Consent for Treatment or SECTION II - Refusal to Consent for Treatment

SECTION I - Consent for Treatment

I hereby give consent for the following medical care providers and local hospital to be called:

Physician:	**Office Phone:**
Dentist:	**Office Phone:**
Medical Specialist:	**Office Phone:**
Hospital:	**Emergency Room Phone:**

And 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 the preferred practitioner indicated or the event the designated preferred practitioner is not available by another licensed physician or dentist and* ***(2)*** *The transfer of the child listed to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.*

Parent/Guardian Signature : ______________________________ **Date:** ______________

SECTION II - Refusal to Consent for Treatment

I do ***not*** *give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action(s):*

____

____

Parent/Guardian Signature : ______________________________ **Date:** ______________

Mac-A-Cheek Learning Center

EMERGENCY MEDICAL FORM Part 2

(Ohio Revised Code 3313.712)

COMPLETE BOTH SIDES OF FORM

Student's Name	**Date of Birth**

Will your child be taking medication at school? Yes ______ No ______
Does your child use a rescue inhaler for asthma(or other respiratory conditions)? Yes ______ No ______
Does your child use an Epinephrine Pen (Epi-Pen) for allergies? Yes ______ No ______

Does your child take any medications? ☐ No ☐ Yes
Please list all medications taken on a regular basis, including over-the-counter, herbal remedies, and vitamins.

Medication	Dosage	Time Taken	Reason for Taking
(example) Ritalin	20mg	7am, Noon, 4pm	Attention Deficit Hyperactivity Disorder

Has your child ever been hospitalized? ☐ No ☐ Yes
Please list and indicate reason for hospitalization.

Reason	Date	Length
(example) took appendix out; (example) depression/threatened suicide	May 20, 2013	4 days

Does your child have an allergies? ☐ No ☐ Yes
Please list all allergies, type of reaction and how it is treated.

Allergy	Reaction (symptoms)	Treatment
(example) Peanut Butter	tongue swells, has problems breathing	Epi-Pen
(example) strawberries	rash	Benadryl

When did your child last have the following:	Date	Physician, Provider, or Clinic
a physical examination?		
a Tetanus immunization?		
a professional vision exam?		
a hearing exam?		
a dental exam?		