BISHOP HOFFMAN CATHOLIC SCHOOL

EMERGENCY MEDICAL FORM 2021-2022

Student Information:

Last Name: _____First Name: _____DOB ____/____/____

Student Address: _____City:_____ County: _____

Sex: M F Ethnicity: _____ Birth Place: _____

Lives with_____ School District/Public School: _____

Religion: _____ Parish where registered: _____

Campus _____ Grade: _____ Homeroom Teacher: _____ Bus #_____

Parent or Guardian contact information:

1st call) Name: _____Relationship: _____

Primary phone number (home/ cell) _____ Secondary phone number (home/cell) _____

Other phone number _____ Employer: _____

Home Address: _____ Email: _____

Ok to text parent/guardian in non-emergency? _____ Ok to email parent/guardian in non-emergency? _____

2nd call) Name: _____Relationship: _____

Daytime phone number (home/ cell) _____ Secondary phone number (home/cell) _____

Other phone number _____ Employer: _____

Home Address: _____Email: _____

Ok to text parent/guardian in non-emergency? _____ Ok to email parent/guardian in non-emergency? _____

Custody Information

Custody arrangements that we need to be aware of_____

Custody papers on file (if applicable)? _____ If not, please provide. Should non- custodial parent receive school communications? _____

Other emergency contacts (in case 1 or 2 cannot be reached)

Call Order	Relationship	Name	Phone #1 (home/work/cell)	Phone#2 (home/work/cell)	can pick up Yes/No
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____
____	_____	_____	_____	_____	_____

Medical information:

Medical condition(s)_____

Allergies_____

Any other needed medical information _____

Medication Name	Dose	Times given	Reason

***Consent to treat on back of form- must fill out either part I or II**

PART I or PART II NEEDS TO BE FILLED OUT BELOW:

PART I: TO GRANT CONSENT

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

Physician _____ Telephone _____ Address_____

Dentist _____Telephone _____ Address_____

Medical Specialist _____Telephone _____ Address_____

**Please note- EMS will take your child to the nearest hospital in an emergency situation. If you have a preference for your child to then be transferred to a different hospital, please specify below:

Hospital: _____ Phone number: _____

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 doctors 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 parent/guardian_____ Date_____

PART II: REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency medical treatment of my child. In cases in which the nature of an illness or an injury appears serious, the parent/guardian(s) are contacted and the instructions on this form are followed, I wish the school authorities to take the following action:

_____

_____

Signature of parent/guardian_____ Date_____

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.
From Ohio revised code 3313.712 Emergency medical authorization

FIRST AID AUTHORIZATION

In the event of minor injuries at school basic first aid measures are performed. For example, a scraped knee on the playground may be treated with antiseptic wash and a Band-Aid, or a mosquito bite may be treated with anti-itch lotion.
By signing this you are stating that basic first aid measures are agreeable and that you consent to the occasional use of certain over-the counter medications can be used for your child if they are needed during school hours. School employees or the school nurse will administer these medications if the student reports their basic first aid complaint at school. These medications may include (but are not limited to): **Anti-itch lotion/spray, antiseptic ointments, antiseptic washes/sprays, petroleum jelly, and cough drops**.
This authorization only includes medications that are "stocked" in the school health office,
No oral medications *or medication from home* will be given to any student without the appropriate physician's orders and parental authorization.

*I release and agree to hold BHCS Board of education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Parents/Guardian name_____Signature_____