BISHOP HOFFMAN CATHOLIC SCHOOL
EARLY CHILDHOOD CENTER

EMERGENCY MEDICAL FORM 2022-2023

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? ___________

List 2 Emergency Contacts for use only if the parents/guardians listed above cannot be reached.

Name: ____ Name: ____

Address: ____ Address: ____

Phone #: ____ Phone #: ____

Medical information:

Medical condition(s)____

Allergies____

Any other needed medical information ____

Medication Name	Dose	Times given	Reason

***Please complete back side. Consent to treat on back of form- <u>must fill out either part I or II</u>**

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. ***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, this includes ointments, etc.

*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____