

## EMERGENCY MEDICAL AUTHORIZATION FORM

School District _____	School Building _____	Home Room Teacher _____	Grade _____
Student's Full Name _____		SSN _____	
Last	First	Middle	
Student's Address _____		P.O. Box/Apt. # _____	City _____
		Street/Road	Zip Code
Student's Birth Date _____		Telephone (____) _____	
Mother's Full Name: _____		Daytime Phone (____) _____	
Email Address _____		Cell Phone (____) _____	
Father's Full Name: _____		Daytime Phone (____) _____	
Email Address _____		Cell Phone (____) _____	
Guardian's/Custodial Parent's Full Name: _____		Daytime phone (____) _____	
Email Address _____		Cell Phone (____) _____	
Name of Relative/Childcare Provider: _____		Telephone (____) _____	
Relative/Childcare Provider Address: _____		Relationship: _____	

**Purpose:** To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

In case of an emergency involving your child and you cannot be reached, list ALTERNATE contacts (local please):

PRIMARY Alternate Emergency Contact: \_\_\_\_\_ Tel.: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Street/Road                      Apt.#/P.O. Box                      City                      Zip Code

SECOND Alternate Emergency Contact: \_\_\_\_\_ Tel.: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Street/Road                      Apt.#/P.O. Box                      City                      Zip Code

**PART I OR PART II MUST BE COMPLETED\***

**Part I** (To Grant Consent): If the school has been unsuccessful in its attempts to contact me, I hereby give my consent for the following medical care providers and local hospital to be called: 1] The administration of any treatment deemed necessary by:

Dr. (physician) \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Or (alternate) Dr. (physician) \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Or in the event neither practitioner is available, by another licensed physician, and 2] The transfer of the child will be to the **nearest** local hospital; if your child has special medical needs, to which hospital would you wish transfer made: \_\_\_\_\_ Hospital Tel.: (\_\_\_\_) \_\_\_\_\_. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians concurring in the necessity for such surgery, are obtained before the surgery is performed.

Dentist \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Date: \_\_\_\_\_ SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

Complete Address: \_\_\_\_\_

List facts concerning the child's medical history to which a physician should be alerted: \_\_\_\_\_

List medication allergies: \_\_\_\_\_

List other allergies: \_\_\_\_\_

List any physical impairments: \_\_\_\_\_

List current medications being taken: \_\_\_\_\_

**HEALTH INFORMATION:** If your child was enrolled in a Clark County school last year, list only the date(s) of any immunization or booster(s) that have taken place since registration last school year so that the school health record can be brought up to date. Complete immunization records are required for students entering a Clark county school for the first time. For more information, call the school or the Clark County Health Department at 390-5615.

<u>Immunization</u>	<u>Date</u>
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____
_____	____/____/____

**\*DO NOT COMPLETE PART II – IF YOU COMPLETED PART I**

Part II (Refusal to Consent) – 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 the following action:

\_\_\_\_\_

Date: \_\_\_\_\_ SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_

Complete Address: \_\_\_\_\_

**CLARK COUNTY HEALTH DEPARTMENT**  
**Community Health Center, 529 East Home Road, Springfield, Ohio 45503**  
**(937) 390-5615**

**IMMUNIZATIONS REQUIRED FOR SCHOOL ADMITTANCE**

The Ohio Department of Health, under the authority granted in Sections 3313.671 and 3701.13, Ohio Revised Code, has established the following minimum requirements for school children:

- FOUR or more doses of D.T.P. or T.D. (Adult) Vaccine or a combination of these vaccines
  - THREE OR MORE DOSES of Trivalent Oral Polio Vaccine (TOPV)
  - ONE measles immunization (Rubeola)
  - ONE rubella immunization
  - ONE mumps immunization
- 1<sup>st</sup> Dose—on or after first birthday and/or before entering school.*

*2<sup>nd</sup> Dose—for students entering Kindergarten and grades 7-12.*

**NOTE: Requirements and Regulations—by American Academy, Pediatricians, State Health Department and Ohio Department of Education**

1. Boosters for diphtheria, whooping cough, tetanus and tri. V. required ONE YEAR AFTER SERIES and BEFORE ENTERING SCHOOL.
2. Any immunization which your child needs to meet the minimum may be obtained from your physician, Western County Clinic, McAdams Early Childhood Center, 1400 Dayton-Lakeview Road, New Carlisle, Ohio (3<sup>rd</sup> Friday of each month – 9:00 a.m. – 12:00 Noon), or at the Clark County Combined Health District, 529 East Home Road, Springfield, Ohio (1st Tuesday of each month, 8:00 a.m. to 7:00 p.m. or the 2<sup>nd</sup>, 4<sup>th</sup>



# FORM C

**Risen Christ Lutheran School**  
41 East Possum Road, Springfield, Ohio 45502

## PHYSICIAN'S EXAMINATION FORM ( )-to be completed by physician

A comprehensive report based upon your findings is necessary in order to assist the teachers, nurses and psychologists of Risen Christ Lutheran School meet the academic, physical and emotional needs of our patient. Please complete this form to the best of your ability and knowledge.

Student's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F

### Immunization Dates

DPT(Tetanus) \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

OPT/IPV(Polio) \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

MMR \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Measles \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Mumps \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Rubella \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis B Vaccine \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Other \_\_\_\_\_: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_

Children born on or after 1/1/98 must have (1) dose Varicella \_\_\_\_/\_\_\_\_/\_\_\_\_

Communicable Diseases (with dates) \_\_\_\_\_

Sickle Cell, Anemia (lab tests) \_\_\_\_\_ Blood Type \_\_\_\_\_

Significant History (include family, perinatal and infant) \_\_\_\_\_

### REPORT FOR ALL STUDENTS

Immunization Boosters: DT(tetanus) \_\_\_\_/\_\_\_\_/\_\_\_\_ Other: \_\_\_\_\_: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight \_\_\_\_\_ lbs. B.P \_\_\_\_/\_\_\_\_/\_\_\_\_ Development(Tanner Stage) \_\_\_\_\_

#### Test Dates Results:

Mantoux(for Tuberculosis) \_\_\_\_/\_\_\_\_/\_\_\_\_

Urinalysis \_\_\_\_/\_\_\_\_/\_\_\_\_

Hemoglobin/Hematocrit \_\_\_\_/\_\_\_\_/\_\_\_\_

Lead Screening \_\_\_\_/\_\_\_\_/\_\_\_\_

Vision \_\_\_\_/\_\_\_\_/\_\_\_\_ O requires correction O referred to specialist

Hearing \_\_\_\_/\_\_\_\_/\_\_\_\_ O requires correction O referred to specialist

Dental Screening \_\_\_\_/\_\_\_\_/\_\_\_\_

Heart Sound (murmurs) \_\_\_\_\_

Scoliosis (screening required by NY State) \_\_\_\_\_

Allergies: (allergen & symptoms & treatment) \_\_\_\_\_

Are there any restrictions on physical activities? O No O Yes (if yes, please specify) \_\_\_\_\_

Other relevant information (i.e. seizures special dietary needs growth): \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date of exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Stamp:

If Stamp not available:

Physicians Name \_\_\_\_\_ fax ( ) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_ Phone( ) \_\_\_\_\_ - \_\_\_\_\_