



**YOUNGSTOWN CITY SCHOOL DISTRICT
EMERGENCY MEDICAL FORM
School Year 2020-2021**

Name: _____ School _____ Grade _____ Teacher _____ DOB _____

Address: _____ City _____ Zip _____ Phone _____

Parent's email: _____ Glasses _____ Contacts _____ Hearing Aid _____ Other _____

Daily Medications (name, dose,time): _____

Allergies (environmental, food, insects, meds): _____

Asthma ___ Diabetes ___ Seizures ___ Epi-Pen _____ Other Conditions: _____

Inhaler _____ Does student actually use inhaler on doctor's orders? yes ___ no ___

Permission to share student's health information with authorized school and emergency personnel: yes ___ no ___

Father _____ Work # _____ Daytime Phone _____ Cell _____

Mother _____ Work # _____ Daytime Phone _____ Cell _____

Other Emergency Contacts if unable to reach parents:

Name/Relationship _____ Daytime Phone _____ Cell _____

Name/Relationship _____ Daytime Phone _____ Cell _____

Name/Relationship _____ Daytime Phone _____ Cell _____

Parent's/Guardian's Signature: _____ Date: _____

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

Physician's Name _____ Phone _____ Fax _____

Dentist's Name _____ Phone _____ Fax _____

Preferred hospital if transportation is necessary _____

Medical Specialist _____ Phone _____

Please Complete Either Part #1 or Part # 2 Below

Part # 1: Grant Consent

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 my designated practitioner(s), or, in the event that the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. ***If ambulance transportation is necessary, parent/guardian is responsible for any charges incurred.** This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessary for such surgery, are obtained prior to the performance of surgery.

Part #2: Decline 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 _____

Parent/Guardian Signature: _____ Date: _____