Diocese of Steubenville
Office of Christian Formation and Schools
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EMERGENCY MEDICAL AUTHORIZATION
Diocesan Form M-1
Required by Section 3313.712 of the Ohio Revised Code

Directions: Please complete and return this form to the school indicated below.

School: _____

Student Name: _____
(First) (M.I.) (Last)

Address: _____

City: _____ Zip_____

Telephone (H)_____

RESIDENTIAL PARENT OR GUARDIAN

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.

Mother's Name: _____ Mother's Daytime Phone: _____

Cell Phone: _____

Father's Name: _____ Father's Daytime Phone: _____

Cell Phone:_____

Name of Relative or Childcare Provider: _____

Relationship to student: _____

Address: _____

Daytime Phone: _____ Cell Phone: _____

Other's Name: _____ Daytime Phone: _____

TURN OVER & SIGN →

PART I OR PART II MUST BE COMPLETED

PART I – TO GRANT CONSENT

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

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Emergency Room Phone: _____

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 doctor, 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.

List any facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Allergies: _____

Current medications: (at home and at school) _____

Other physical and medication conditions: (EXAMPLE: diabetes, seizures, disorders)

_____

_____

_____

SIGN HERE → Parent/Guardian _____ Date _____

Address: _____
(If different from student address)

S T O P HERE IF YOU HAVE COMPLETED PART I

PART 2 – REFUSE 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:

_____

_____

SIGN HERE TO REFUSE → Parent/Guardian: _____ Date: _____

Dear Parent/Guardian,

We are required by The Steubenville Diocesan office to obtain **WRITTEN PERMISSION** from the parent or guardian permitting us to dispense any medications. This also includes over the counter medications (OTC). Without your written permission **NO** over the counter medications will be dispensed to your child during school hours.

If your child will require any OTC medications on a regular on-going basis we will need a physician's approval. Also, please note if a medication other than what is listed below needs to be given to your child during school hours, please send the medication to school clearly labeled with the name of student in the original bottle with the physician order or instructions.

Please check the following OTC medications that we have permission to dispense to your child.

Acetaminophen (Tylenol) _____

Ibuprofen (Advil, Motrin) _____

Antacids (Tums) _____

Cough Drops _____

Student_____ Grade_____

Allergies_____

_____ I request to be notified when my student receives OTC medication.

Phone number you would like used for notification: _____

_____ I do not need to be notified when my student receives one of the OTC medications listed above.

Please regard my signature as my assurance that I release CCHS and any of the school's officers/employees from liability resulting from the consequences or adverse reactions of my child taking or failing to take this medication.

_____

Signature of Parent/Guardian Date

7/2019

STEUBENVILLE CATHOLIC CENTRAL HIGH SCHOOL

August 1, 2019

Dear Parent/Guardian,

If you have listed an allergy or medical condition on the Emergency Medical Authorization (EMA) form that may require immediate attention and intervention by CCHS staff, for the well-being of your son/daughter I feel that it would be a benefit to inform your son/daughter's teachers, coaches and office staff of the allergy and/or medical condition listed, in case of a medical emergency. By signing and returning this form, it will be noted that you grant me permission, or not, to share those allergies and or medical conditions with the above mentioned staff at CCHS. All information shared with CCHS staff for the benefit of your child, will be labeled as confidential information and maintained as such by all CCHS staff involved.

Sincerely,

Tammie Bensur, RN BSN

Mrs. Tammie Bensur, RN BSN
CCHS School Nurse

Student Name: _____ Grade: _____

_____ I grant permission for the school nurse to share the allergy and/or medical condition of my son/daughter that I have listed on the EMA form, with the teaching/coaching and office staff of CCHS.

_____ I **DO NOT** grant permission for the school nurse to share the allergy and/or medical condition of my son/daughter that I have listed on the EMA form, with the teaching/coaching and office staff of CCHS.

_____ _____

Parent Signature Date

Please note that this form will be maintained in the student health file and a new form must be signed for every school year that your child attends CCHS

320 Westview Avenue Steubenville OH 43952 office: 740 264 5538 fax: 740 264 5402 website www.steubenvillecatholicschools.org