

Western Local Schools
Emergency Medical Authorization Form (EMA)
Elementary Phone: 740-493-2881 Fax: 740-493-1059
JR/ High School Phone: 740-493-2514 Fax: 740- 493-8513

Today's Date _____ School Year _____ Grade _____ Teacher _____

Status: Please Check One:

New ___ Re-enrolled ___ Current ___

SS# _____

AM BUS # _____ PM BUS _____

Last school district attended _____

Student's Name _____

Date of Birth _____ **Male** ___ **Female** ___

Address _____

_____ **Zip** _____

EMA – Purpose: To enable parents and guardians to **authorize the provision of emergency treatment and /or pick up** for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Please list all emergency numbers on this form.

Parent or Guardian

Mother's Name _____

Father's Name _____

Other's Name _____

Other's Name _____

Home Phone _____

Phone (____) _____

Phone (____) _____

Phone (____) _____

Phone (____) _____

List Brothers & Sisters or other children living in the home: Please put both First & Last names.

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Grant Consent Part 1:

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

Physician _____ Phone (____) _____

Dentist _____ Phone (____) _____

Medical Specialist _____ 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 the above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; (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.

I give my consent for the release of medical information to school personnel.

List facts concerning the child's medical information: Diagnosis _____

Medications Currently Taking: _____

Allergies: _____

Physical Impairments: _____

Date: _____ **Signature of Parent/Guardian** _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

Part II: Refusal To Consent (Only sign Part II IF YOU DO NOT CONSENT FOR EMERGENCY MEDICAL TREATMENT). I do not 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 _____