

**Emergency Medical Authorization**  
Miami Valley Career Technology Center  
Pursuant to Section 3313.72, Ohio Revised Code

_____	Student Name
Home School _____	Street Address _____
Career-Technical Program at MVCTC _____	City _____ State _____ Zip Code _____
Date of Birth _____	Home Phone _____ Is Pre-Printed Information Correct? No _____ Yes _____

**If Pre-Printed information is not correct, please make appropriate changes.**

**RESIDENTIAL PARENT OR GUARDIAN (Please indicate if listing step-parents):**

Mother's Name: _____	Daytime Phone: _____	Cell: _____
Father's Name: _____	Daytime Phone: _____	Cell: _____
Guardian's Name: _____	Daytime Phone: _____	Cell: _____

**EMERGENCY CONTACTS (Staff will call in order listed, if parent/guardian CAN NOT be reached):**

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

**HEALTH INFORMATION (Medication forms are available from the clinic or MVCTC web site: [www.mvctc.com/wellness](http://www.mvctc.com/wellness)):**

Allergies: No \_\_\_\_\_ Yes \_\_\_\_\_ Specify \_\_\_\_\_

Epi-Pen: No \_\_\_\_\_ Yes \_\_\_\_\_ **Epi-Pen Medication Form must be completed and signed by a physician if student carries Epi-Pen.**

Asthma: No \_\_\_\_\_ Yes \_\_\_\_\_ **Asthma Inhaler Medication Form must be completed and signed by a physician if student carries inhaler.**

Diabetes: No \_\_\_\_\_ Yes \_\_\_\_\_ Name(s) of Medications: \_\_\_\_\_

Indicate daily medications and /or health problems: \_\_\_\_\_

\_\_\_\_\_

**PART I- TO GRANT CONSENT – (PART I OR PART II MUST BE COMPLETED)**

Doctor: _____	Telephone: _____
Dentist: _____	Telephone: _____
Preferred 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 emergency medical 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.*

Signature of Custodial Parent _____	Address of Custodial Parent _____	Date _____
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<b><u>PART II- REFUSAL TO CONSENT- DO NOT COMPLETE IF YOU COMPLETED PART I</u></b>		
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 no action; however, medical situations may be referred to appropriate medical personnel if deemed necessary:		
Signature of Custodial Parent _____	Address of Custodial Parent _____	Date _____