

# Kettering City School District

WILLIAM J. LAUTAR, DIRECTOR  
STUDENT SERVICES  
(937) 499-1433 FAX (937) 499-1468

Dear Parents:

The form on the other side is provided to you in accordance with Section 3313.712 of the Revised Code of the State of Ohio.

We urge you to read the purpose as stated on the form, then complete either Part I or Part II and return the completed form to your child's school.

Be sure you complete a form for each of your children. If a form is lost, or one of your children does not bring a form to you, call the school office and request that another form be sent home with your child.

If, at any time, you wish to make a change in what you have put on the form, you may call your child's school and request another blank for completion.

Sincerely,



William J. Lautar  
Director  
Student Services



(See letter - other side)

KETTERING CITY SCHOOL DISTRICT - EMERGENCY MEDICAL AUTHORIZATION  
Section 3313.712, Ohio Revised Code

Student Name _____	School Attending _____	Grade _____	Date of Birth _____
Address _____			Telephone _____

**INSTRUCTIONS TO FATHER, MOTHER, GUARDIAN:** You are to complete either Part I or Part II of this form and return it to your child's school within 10 days after you receive it.

Purpose - To enable parents and guardians to authorize the provision or emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential parent or guardian:

Mother's Name _____	Home # _____	Work # _____	Cell # _____
Father's Name _____	Home # _____	Work # _____	Cell # _____
Other's Name _____	Home # _____	Work # _____	Cell # _____

Name of relative or child care provider: \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

**PART I OR 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 _____	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 concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician and school personnel should be alerted: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date \_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_  
 Address \_\_\_\_\_

(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 \_\_\_\_\_  
 Address \_\_\_\_\_