Student's Name:

Program: ◯Jr. ◯Sr.

Lab Instructor:

Purpose of this form: 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.

Student Information:

Birthdate: Soc. Sec #:

Address:

Home Phone: ZIP Code:

Partner School:

Insurance Co. :

Insurance Group #:

Residential Parent or Guardian:

Mother's Name:

Address:

Home Phone: Work Phone:

Place of Employment:

Father's Name:

Address:

Home Phone: Work Phone:

Place of Employment:

Name of relative(s) or other person(s) in case of illness or emergency:

Name:

Address:

Relationship: Phone:

Name:

Address:

Relationship: Phone:

Pioneer Career and Technology Center
27 Ryan Road Shelby, OH 44875 Phone: 877-818-7282

Emergency Medical Authorization Form 2017-2018

Student Medical History:

The information that you provide on this form is to be used for emergency purposes and only released to emergency personnel, Pioneer staff (for lab and field trips) and the School Nurse.

Please provide specific information concerning the student's medical history.

Date of last tetanus immunization:
(If more than 10 years, have student re-immunized)

Allergies to medications, bee stings, etc.
(Please list symptoms of reaction):

Current medications:

Chronic illnesses; physical limitations or medical conditions:

Other:

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

Initial in box at the left to grant consent, complete the section below, then sign & date at the bottom.

I hereby give consent for the following medical care providers and local hospital to be called: **(Note: Students may not work in laboratory setting until form is completed, which includes the phone numbers below.)**

Physician: 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 doctors, 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 accessible.

PART II: REFUSAL TO GRANT CONSENT

Initial in box at the left if refusing to grant consent, complete the section below, then sign & date at the bottom.

I **DO NOT** give my consent for emergency medical treatment of my chld. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the action outlined below:

Action to be taken:

INITIAL PART I OR PART II ABOVE indicating how you would like us to proceed. THEN SIGN AND COMPLETE THIS SECTION.

Date

Signature of Parent/Guardian **(REQUIRED)**

Address:

Zip Code: