GRANVILLE CHRISTIAN ACADEMY

Emergency Medical Authorization

Purpose: to enable parents and/or guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. (OHIO REVISED CODE 3313.712)

Student Information

Student Name: _____

Address: _____

_____

Grade Entering: _____ Phone: _____

Public School District: _____ Date of Birth: _____

Parent Information

Please list, in order of preference, parents, guardians, relatives, or child care providers that you would like to have contacted in the event of an emergency involving your child.

Parent/Guardian One

First Name: _____

Last Name: _____

Place of Employment: _____

Address (if different than above):

_____

_____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Relationship to Applicant: _____

Parent/Guardian Two

First Name: _____

Last Name: _____

Place of Employment: _____

Address (if different than above):

_____

_____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Relationship to Applicant: _____

Additional Contact One

First Name: _____

Last Name: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Relationship to Applicant: _____

Additional Contact Two

First Name: _____

Last Name: _____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Relationship to Applicant: _____

Parent/Guardian email to be used for school notification: _____

PART ONE OR TWO BELOW MUST BE COMPLETE

Part One (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:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Part Two (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 or dentists, 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, past medical history, and any physical impairments to which a physician should be alerted:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Return completed form to:

Granville Christian Academy: Attention Enrollment Director

1820 Newark Granville Road

Granville, Ohio 43023

Forms can also be emailed to admissions@granvilleca.org.