Loveland High School
Athletic Emergency Medical Authorization

This emergency Medical Authorization, required by O.R.C. 3313.712, must be on file for each student.
Purpose: 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/guardians cannot be reached. **PLEASE PRINT AND RETURN WITH PAPERWORK.**

Student's Name ________________________ Date of Birth ____________________ Grade _______

Student's Address ____

Mother's Name ________________________ Home Phone ______________ Work Phone ___________

Address (if different from student's) ____

Father's Name ________________________ Home Phone ______________ Work Phone ___________

Address (if different from student's) ____

List in order person(s) who may be notified and to whom your child may be released if the school cannot reach you:

Name	Relationship	Home Phone	Work Phone	Cell/Pager #

Facts concerning the child's medical history including allergies, medications and any physical impairment to which a physician should be alerted ____

Doctor to be called ____ Phone ____________________

Dentist to be called ____ Phone ____________________

Preferred Local Hospital ____

Part I – TO GRANT CONSENT

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 doctor or in the event the designated preferred physician 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.

Date ____________________ Signature of parent/guardian ____

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 ____

PROOF OF INSURANCE: A COPY OF YOUR MEDICAL INSURANCE CARD (FRONT AND BACK) must be attached.
If you have no insurance coverage – attach a signed waiver obtained from the coach or athletic office.