# Our Lady of the Lake School

## Pre-Kindergarten Emergency Medical Authorization

Child's Name: _____ Date: _____
Address: _____ Zip: _____ Phone: _____
Father's Place of Business: _____ Phone: _____
Mother's Place of Business: _____ Phone: _____

If your child becomes ill and both parents work, which parent should be called first? _____

Persons To Be Notified If Parents Cannot Be Reached

1. Name: _____ Phone: _____
2. Name: _____ Phone: _____

Purpose: Persons given permission to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Person(s) given permission to provide emergency transportation. _____

Part 1 (To Grant Consent)

In the event reasonable attempts to contact me at (___)_____, or other parent at (___)_____ have been unsuccessful, I hereby give my consent for [1.] the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____ (preferred dentist) 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 _____ (preferred hospital) or 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 before the surgery is performed.

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

_____

_____ _____ _____

Father's Signature Mother's Signature Date

Do Not Complete Part 2 If You Completed Part I

Part 2

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 medical treatment, I wish the school authorities to take no action or to: _____

_____

_____

_____

_____ _____ _____

Father's Signature Mother's Signature Date

Ohio Department of Job and Family Services

# CHILD MEDICAL STATEMENT FOR CHILD CARE

| Child's Name *(print or type)* | Date of Birth |
|---|---|
| | |

✓ This above named child has been examined, the immunization status recorded, and the child is in suitable condition for participation in group care.

✓ This above named child has been immunized in accordance with the requirements of section 5104.014 of the Ohio Revised Code (please note any exceptions below).

| **Signature** of Examining Physician/Physician's Assistant/Advanced Practice Registered Nurse/Certified Nurse Practitioner | Date of Examination |
|---|---|
| | |

| Name of Physician/Physician's Assistant/Advanced Practice Nurse/Certified Nurse Practitioner | Telephone Number |
|---|---|
| | |

| Street Address |
|---|
| |

| City, State and Zip Code |
|---|
| |

***ATTACH A COPY OF THE CHILD'S IMMUNIZATION RECORD WITH DATES OF DOSES OF ALL IMMUNIZATIONS***

**Exceptions to Immunization requirements pursuant to 5104.014 ORC** (please include names of requirement diseases against which the child has not been immunized and whether it is because the immunization is medically contraindicated, not medically appropriate for the child's age, or declined by the parent).

☐ I have declined to have my child immunized against one or more of the diseases required by 5104.014 of the Ohio Revised Code. Please note disease above and sign.

| Signature of Parent | Date of Signature |
|---|---|
| | |

**Optional**

**Recommended Assessments/Screenings**

| | | | |
|---|---|---|---|
| Vision | ☐ Yes ☐ No | Lead | ☐ Yes ☐ No |
| Hearing | ☐ Yes ☐ No | Hemoglobin | ☐ Yes ☐ No |
| Dental | ☐ Yes ☐ No | Other | |

| **Measurements** | | **Notes** |
|---|---|---|
| Height | | |
| Weight | | |
| BMI | | |

STUDENT NAME

_____

OUR LADY
OF THE LAKE SCHOOL

Preschool Emergency Medical Authorization (Additional Contact Information)

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Dentist: _____

Address: _____ Phone: _____

Local Preferred Hospital: _____

Location: _____

Emergency Room Phone: _____

OUR LADY
OF THE LAKE SCHOOL

Preschool Emergency Medical Authorization (Additional Contact Information)

Preferred Physician: _____

Address: _____ Phone: _____

Preferred Dentist: _____

Address: _____ Phone: _____

Local Preferred Hospital: _____

Location: _____

Emergency Room Phone: _____