MEDICAL AUTHORIZATION
(Form E – 1) 2009 - 2010 **Deadline: August 1, 2009**

Student Name _____ **Grade** _____

Andrews Osborne ACADEMY

EMERGENCY/ROUTINE CARE MEDICAL AUTHORIZATION

PURPOSE: To enable parents and/or guardians to authorize **emergency, routine, and/or mental health** treatment for their student who becomes ill or injured while under school authority when parents cannot be reached**. Either Part I or Part II must be completed.**

PART I – AUTHORIZATION

I AUTHORIZE MY CONSENT for any required hospital admission and necessary medical/mental health treatment. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before 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:

_____

_____ _____

Date **Signature of Parent or Guardian**

PART II – REFUSAL

DO NOT SIGN IF YOU SIGNED PART I

I DO NOT GIVE MY CONSENT for emergency medical/mental health treatment of my child. In the event of an illness or injury requiring emergency treatment, I direct the school authorities to take **NO** action and to do the following:

_____ _____

Date **Signature of Parent or Guardian**

NON-EMERGENCY MEDICAL & MEDICATION AUTHORIZATION

Ohio law mandates that all school systems have on file a statement signed by BOTH the parent and/or guardian AND the physician for all medications – both prescription and non-prescription over-the-counter pharmacy medications – that are administered to students. For your convenience in obtaining physician signatures, a form for this is included separately. No medication, including Tylenol, can be given to your child without this authorization. Please complete and return **Medical Forms H-1 and H-2.**

MEDICAL INSURANCE REQUIREMENTS

- If the student is a U.S. citizen, and has medical insurance, please complete the form below and **also attach a copy of the current insurance card.**
- If the student is a U.S. citizen and does NOT have insurance, please attach a written statement signed by the parent and/or guardian accepting full responsibility for all physician and hospital charges.
- If the student is NOT a U.S. citizen, a policy will be provided for the student through **HTH Worldwide** and the cost will be charged to the student's account. **ALL INTERNATIONAL STUDENTS MUST HAVE INSURANCE**.

MEDICAL INSURANCE INFORMATION		
Name of Subscriber	Hospital Plan	Medical Insurance Company
Contract No.	Group No.	Address for Insurance Company
Service Code	Contact Name	Telephone No. for Insurance Company

►► PLEASE ATTACH COPY OF CURRENT INSURANCE CARD ◄◄

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