



# Olney Friends School

61830 Sandy Ridge Road, Barnesville, OH 43713  
www.olneyfriends.org

## AUTHORIZATION FOR MEDICAL TREATMENT

Purpose: To enable parents to authorize medical treatment for their child when he/she becomes ill/injured while under the care of Olney Friends School.

Student Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ SSN# \_\_\_\_\_

HOME Address \_\_\_\_\_

Parent/Guardian Contact Information:

- |                        |                  |
|------------------------|------------------|
| 1) Mother name _____   | Home phone _____ |
| Work phone _____       | Cell phone _____ |
| 2) Father name _____   | Home phone _____ |
| Work phone _____       | Cell phone _____ |
| 3) Guardian name _____ | Home phone _____ |
| Work phone _____       | Cell phone _____ |

Please name at least one other adult relative whom the school may call to authorize medical treatment in the event you cannot be contacted:

Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

If your child becomes ill/injured while under the care of Olney Friends School, the school nurse or her designee will make every effort to contact you. In the event that non-emergency medical care (i.e. Strep throat, tonsillitis, sprains, strains) is warranted, the school nurse will make every effort to contact you, so as to inform you of your child's condition and of the need for evaluation by a qualified physician. The school nurse or her designee will accompany your child to the appointment.

In the case of emergency or serious illness/injury, you may not be notified until after medical attention is sought and the situation is under better control. The school nurse or her designee will accompany your child or meet them at Barnesville Hospital if your child needs to be transported by ambulance.

In the event reasonable attempts to contact parent/guardian or designated adult listed above have been unsuccessful, I hereby give my consent for:

- 1) Evaluation and treatment by a physician or other specialist as deemed necessary.
- 2) Emergency treatment by a physician or Barnesville Hospital.
- 3) Transfer of my child to Barnesville Hospital or other medical facility by car or ambulance.

Medical history to which a physician should be alerted:

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Date of last Tetanus booster: \_\_\_\_\_

Medical history: \_\_\_\_\_

Surgical history: \_\_\_\_\_

Special requests/concerns: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date: \_\_\_\_\_