

THIS FORM IS FOR PRESCHOOL STUDENTS ONLY

2026 - 2027 EMERGENCY MEDICAL AUTHORIZATION

This form must be filled out and returned on or before the first day of school

SCHOOL DISTRICT: Archdiocese of Cincinnati

SCHOOL ATTENDING: **Our Lady of the Visitation**

(PLEASE PRINT):

STUDENT'S LAST NAME _____

STUDENT'S FIRST NAME _____

DATE OF BIRTH _____ GRADE _____

HOMEROOM TEACHER _____

HOME ADDRESS _____

HOME PHONE _____

MOTHER'S NAME _____

FATHER'S NAME _____

MOTHER'S CELL _____

FATHER'S CELL _____

MOTHER'S EMAIL _____

FATHER'S EMAIL _____

In the event of an emergency or to verify the absence of my child from school (if the school has not been notified by 8:30 a.m.)

PLEASE CONTACT:

1. _____	_____	_____	_____
Name	Relation	Phone #	Email Address

2. _____	_____	_____	_____
Name	Relation	Phone #	Email Address

2. _____	_____	_____	_____
Name	Relation	Phone #	Email Address

PART I OR II MUST BE COMPLETED

PART 1 TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name _____ Phone # _____

Dentist's Name _____ Phone # _____

Local Hospital _____ ER 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-name 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.

Date

Signature of Parent or Guardian

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II

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 or Guardian

PLEASE COMPLETE OTHER SIDE

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HAMILTON COUNTY EDUCATIONAL SERVICE CENTER

STUDENT HEALTH HISTORY UPDATE

STUDENT _____ GRADE _____ ROOM _____

Please complete this form and return it to school as soon as possible. Having up-to-date health information allows better care and understanding of your child's needs if problems arise during the school day. If there are any future changes in your child's health status, please call the school nurse at 513-451-7207 or send a note to school. **Check all health conditions your child may have.**

ADD / ADHD (Please circle)

ALLERGIES or reactions to: (Please explain)

Food(s) _____

Medication(s) _____

Plant / Animal / Environmental / Seasonal _____

ASTHMA (Identify triggers)

Has your child ever needed emergency treatment for asthma?

___ YES ___ NO

BLADDER PROBLEMS (Please explain)

BOWEL PROBLEMS (Please explain)

CYSTIC FIBROSIS

DIABETES Age of diagnosis _____

EAR INFECTIONS (frequently after age of 3)

Approximate date or age of last infection _____

Currently under the care of ENT? ___ YES ___ NO

Currently has PE tubes? ___ YES ___ NO

Date of last ENT appointment _____

EATING DISORDER

EMOTIONAL/ BEHAVIORAL CONCERNS

EYE PROBLEMS (Please explain)

Wears glasses/contacts? ___ YES ___ NO

Date of last eye examination _____

HEADACHES (frequent)

Migraines? ___ YES ___ NO

HEART CONDITION (Please explain)

KIDNEY DISEASE (Please explain)

MENSTRUAL PROBLEMS (Please explain)

PHYSICAL DISABILITY (Please explain)

**RECENT HOSPITALIZATION/SURGERY
SIGNIFICANT INJURY** (Please explain)

SICKLE CELL DISEASE (not trait)

Date of last sickle cell crisis _____

SEIZURES / EPILEPSY

Date of last episode _____

SPINAL CURVATURE (scoliosis, etc.)

Currently under the care of an orthopedic doctor?

___ YES ___ NO

TICS / NERVOUS TWITCHES

My child takes the following daily medication(s) _____

My child takes the following medication(s) occasionally _____

Please identify any other health information not listed above that you believe school personnel need to be aware of _____

NONE OF THE ABOVE APPLIES TO MY CHILD.

This information may be shared with school personnel if it is pertinent to health and safety, educational progress and/or behavioral management plan.

Parent/Guardian Signature _____ Date _____

PLEASE COMPLETE OTHER SIDE