School Year 2015-2016

Tiffin City Schools
Staff Emergency Medical Form

Building: _____

Name _____ Phone number _____

Address _____ City, State, Zip _____

Title _____ Date of Birth _____

Allergies _____

Medications _____
_____
_____

IN CASE OF MEDICAL EMERGENCY, SCHOOL OFFICIALS SHOULD CONTACT:

	Primary Contact	Secondary Contact
Name	_____	_____
Relationship	_____	_____
Employer	_____	_____
City	_____	_____
Daytime Phone Number	_____	_____
Daytime Cell Phone Number	_____	_____

Physician _____ Physician Phone _____

Dentist _____ Dentist Phone _____

Hospital _____ Hospital Phone _____

I give my consent that in the event that my doctor and/or dentist is not available, another licensed medical professional in the field may administer treatment deemed necessary. If my preferred hospital is too far away, I give permission to be transported to any hospital reasonably accessible. (MUST check one) ___ Yes ___ No

Signature _____ Date _____

I do **NOT** give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish authorities to take the following action: _____
_____

Signature _____ Date _____