WAYNE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
EMERGENCY MEDICAL AUTHORIZATION

TO BE UPDATED ANNUALLY

Date Completed:_____

LEGAL NAME:_____ Date of Birth::_____

ADDRESS:_____ Home Phone:_____
Street City State Zip

Cell Phone: _____

SS# _____ Medicare# _____ Medicaid #_____

	Name	Address	Phone	Employer/Shift/Phone
Mother/Responsible Party				
Father/Responsible Party				
Group Home Name (if applicable)				
Court Appointed Guardian				

EMERGERCENCY BACKUP: IDENTIFY TWO PEOPLE THAT LIVE OUTSIDE THE HOME that have a telephone and available transportation who have agreed to relay a message and/or pick up the individual in an emergency.

1. _____

2. _____
Name Address Phone

HEALTH INFORMATION

INDIVIDUAL'S: Height: _____feet _____inches Weight: _____lbs. Age: _____yrs.

Last Physical Exam:_____ Last Vision Exam: _____Last Dental Exam:_____
Date Date Date

Immunizations Last Year: Type/Date: _____Last Tetanus: _____

Medical Diagnosis Problems/Syndrome	Physical Limitations	Food Restrictions	Allergies

LIST ALL CURRENT MEDICATIONS THE INDIVIDUAL TAKES DAILY, **WHETHER AT HOME OR SCHOOL**.
IF NO MEDICATION IS TAKEN, WRITE **NONE.**

Name and Dose of Medication	Name and Dose of Medication	Name and Dose of Medication

NOTE: Services will be interrupted if current emergency information is not provided. It is the responsibility of the parent/guardian/caregiver to inform the school nurse immediately of changes in this information. ORC3313.712

I, Parent / Guardian Name_____ authorize the nursing staff of the Wayne County Board of Developmental Disabilities to administer the following over the counter medications as needed. Please check those that you give permission to the nurses to administer.

_____Acetaminophen (Tylenol) _____ Sunscreen _____ Insect Repellant _____ Skin Barrier

_____ Hydrocortisone 1% Cream _____ Triple Antibiotic Ointment _____ Diphenhydramine (Benadryl)

Does the individual have seizures? ☐ Yes ☐ No If yes, give the date of last seizure: _____

How long does a seizure last? _____ (minutes/seconds) How often do they occur?_____

BEFORE, DURING, OR AFTER A SEIZURE, DO ANY OF THE FOLLOWING OCCUR? (please check)

☐ Cries Out ☐ Rolls Eyes ☐ Urinates ☐ Twitches ☐ Becomes Confused ☐ Becomes Rigid

☐ Falls Down ☐ Skin Color Changes ☐ Becomes Unconscious ☐ Body Jerks ☐ Vomits

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IMPORTANT – YOU MUST COMPLETE AND SIGN EITHER PART I OR PART II BELOW

PART I **TO GRANT CONSENT**

In the event reasonable attempts to contact me at _____(phone) or to contact _____(other parent or guardian) _____(phone) have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by Dr. _____(physician) (address) (phone) or Dr. _____(dentist) (address) (phone) or in the event these are not available, by any other licensed physician or dentist, and (2) the transfer of the individual to _____(preferred hospital) _____ or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Individual's Signature Date Parent/Guardian Signature Date

OR

PART II **REFUSAL TO CONSENT**

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

_____

_____

_____ _____

Individual's Signature Date Parent/Guardian Signature Date

ADVANCED DIRECTIVES

None _____ **Living Will** _____ **DNRCC** _____ **DNRCC Arrest** _____

Ordered by _____

Revised 4/16/2021