

CLOVERLEAF LOCAL SCHOOLS
ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION - Students 2010-2011

NAME (Last) (First) (Middle) PHONE SCHOOL

RESIDENCE ADDRESS (Street/Road Number) (Post Office) (Zip)

MAILING ADDRESS (Box Number) (Post Office) (Zip)

BIRTHDATE (Month/Day/Year) Male Female GRADE BUS#(AM) BUS#(PM)

CITY OF BIRTH HOMEROOM TEACHER HR#

PART I OR PART II Must Be Completed

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me at (home phone) OR at work (phone # is below);

Mother's Name Place of Work Phone Cell #

Father's Name Place of Work Phone Cell #

STUDENT RESIDES WITH: Mother Father Both Grandparent Other

Or-If neither parent can be reached, I give permission for you to contact the following;

Name Relationship Phone Cell #

Name Relationship Phone Cell #

and/or I hereby give my consent for: (1) the administration of any treatment deemed necessary by:

Dr. (preferred physician) Phone O R

Dr. (preferred dentist) Phone O R

in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to

(preferred hospital) (Phone)

OR TO ANY HOSPITAL REASONABLY ACCESSIBLE.

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

Please provide facts concerning the child's medical history including allergies, medications being taken and any physical impairments of which the school should be aware (be specific) or indicate "none known".

Blank lines for medical history details.

Parent/Guardian Signature (verifying information and consent)

Date

PART II - REFUSAL TO CONSENT - (DO NOT COMPLETE THIS PART IF PART I WAS COMPLETED)

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 no action or to:

Signature of Parent or Guardian Date

Address