

CLOVERLEAF LOCAL SCHOOLS
ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION - Students

S-14a (Rev7/10)

NAME _____ PHONE _____ SCHOOL _____
(Last) (First) (Middle)
RESIDENCE ADDRESS _____
(Street/Road Number) (Post Office) (Zip)
MAILING ADDRESS _____
(Box Number) (Post Office) (Zip)
BIRTHDATE _____ Male ☐ Female ☐ GRADE _____ BUS#(AM) _____
(Month/Day/Year) 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. _____ Phone _____ OR
(preferred physician)

Dr. _____ Phone _____ OR
(preferred dentist)

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".

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 _____

** Only people listed will be able to sign children out.*