CLAYMONT CITY SCHOOLS

201 N. Third St. **Dennison, OH 44621** **(740) 922-5478**

School _____ Student's Name _____

Grade _____ Birthdate_____

Teacher _____ Address _____

_____ Zip_____

Home Telephone (_____)_____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill while under school authority.

Residential Parent or Guardian:

Name _____ Relationship_____

Address _____ Cell Phone (_____) _____

_____ Zip _____ Daytime Phone (_____) _____

Name _____ Relationship_____

Address _____ Daytime Phone (_____) _____

_____ Zip _____ Cell Phone (_____) _____

When parents or guardians cannot be reached, I authorize the following people to pick up my child:

Name _____ Relationship _____

Daytime Phone (_____) _____

Address _____ Cell Phone (_____) _____

Name _____ Relationship _____

Daytime Phone (_____) _____

Address _____ Cell Phone (_____) _____

Name _____ Relationship _____

Daytime Phone (_____) _____

Address _____ Cell Phone (_____) _____

Name _____ Relationship _____

Daytime Phone (_____) _____

Address _____ Cell phone (_____) _____

PART I OR II MUST ALSO BE COMPLETED
(See reverse side)

PART I: TO GRANT CONSENT

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

Physician _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Medical Specialist _____ Phone (_____) _____

Local Hospital _____ 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 the above-named doctors, 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 of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

This information will be shared with the appropriate school personnel as needed.

Date _____ Signature of Parent/Guardian _____

Address _____

_____ Zip _____

PART II: REFUSAL TO CONSENT

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/Guardian _____

Address _____

_____ Zip _____

Revised 5/5/17