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 ___________