LEIPSIC LOCAL SCHOOLS
SCHOOL YEAR - ____________
EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name ____ Grade______ Birth Date ___________

Home Address ____ Phone _________________________

City/State ____ Bus Number/Driver _______________

Family E-mail address ____

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.

Residential Parent or Guardian

Mother's Name ______________________________________ Daytime Phone ________________________
Work Place Cell Phone ____________________________

Father's Name ______________________________________ Daytime Phone ________________________
Work Place Cell Phone ____________________________

Other's Name _______________________________________ Daytime Phone ________________________
Work Place

Name of Relative or Childcare Provider to be contacted in the event parents cannot be reached:

1. ____ Phone ____________________________
Name and Address Relationship

2. ____ Phone ____________________________
Name and Address Relationship

EVENT PERMIT

__________________________ has my permission to go with a school chaperoned group for athletic events away from the building.

____________________________________ ______________
Signature of Parent/Guardian Date

PUBLICITY PERMIT/CLASS ROSTER

The Leipsic Local Schools have permission to use by child's name and photograph in any school related news release to local and area newspapers, school website and to make available, upon request student directory information.

____________________________________ ______________
Signature of Parent/Guardian Date

-- COMPLETE BACK SIDE OF FORM FOR CONSENT --

PART I OR II MUST BE COMPLETED TO GRANT CONSENT

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

______________________________	______________________________
Doctor's Name	Phone Number
Dentist's Name	Phone Number
Medical Specialist	Phone Number
Local Hospital	Emergency Room Phone Number

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 above-named doctor, 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 for 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:

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Date ______________________ Signature of Parent/Guardian ______________________

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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:

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Date ______________________ Signature of Parent/Guardian ______________________