LEIPSIC LOCAL SCHOOLS – 2015-2016
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

FIELD TRIP PERMIT

(Student Name)_____ has my permission to go with a school chaperoned group on field trips 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:**

_____

_____

_____

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:

_____

_____

_____

Date	Signature of Parent/Guardian