S-14a (Rev7/10)

CLOVERLEAF LOCAL SCHOOLS
ACTIVITIES EMERGENCY MEDICAL AUTHORIZATION - Students

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 ____