

# CLAYMONT

# CITY

# SCHOOLS

201 N. Third St.

Dennison, OH 44621

(740) 922-5478

School \_\_\_\_\_ Student's Name \_\_\_\_\_  
Grade \_\_\_\_\_ Address \_\_\_\_\_  
Teacher \_\_\_\_\_ 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, when parents or guardians cannot be reached.

**Residential Parent or Guardian:**

Mother's Name \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

Guardian's Name \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_

**Relatives and/or Childcare Provider:**

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 \_\_\_\_\_