CONTINENTAL HIGH SCHOOL -- 2017-2018
EMERGENCY MEDICAL AUTHORIZATION

Student's Name _____ Grade _____ Locker _____

Home/Primary Phone _____ Birthdate _____ Bus #/Driver _____

Street Address _____

Mailing Address _____

Student resides with (circle all that apply) Mother Father Stepparent Guardian
Other, list relationship _____

Who has legal custody? _____

Court custody order: Yes ☐ No ☐ If yes, court papers submitted to the school office: Yes ☐ No ☐

Mother's Information

Name _____
Address _____
City _____ Zip _____
Email _____
Home Phone _____
Cell Phone _____
Work/Daytime Phone _____
Employer _____

Father's Information

Name _____
Address _____
City _____ Zip _____
Email _____
Home Phone _____
Cell Phone _____
Work/Daytime Phone _____
Employer _____

Guardian's Information

Name _____
Address _____
City _____ Zip _____
Email _____
Home Phone _____
Cell Phone _____
Work/Daytime Phone _____
Employer _____

Other's Information

Name _____
Address _____
City _____ Zip _____
Email _____
Home Phone _____
Cell Phone _____
Work/Daytime Phone _____
Employer _____

Relative or Childcare Provider to be contacted in the event parents cannot be reached when the child is ill or requires transportation from school. Please list three.

	Name	Relationship	Phone Numbers
1st			
2nd			
3rd			

Field Trip Permit

_____ 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 Continental Local Schools have permission to use my child's name and photograph in any school related news release to local and area newspapers and to make available upon request student directory information.

Signature of Parent/Guardian _____ Date _____

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 OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialst _____ Phone _____

Local Hospital _____ Emergency Room 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 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, medication being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____

Signature of Parent/Guardian _____ Date _____

Address _____

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:

_____

_____

_____

Signature of Parent/Guardian _____ Date _____

Address _____