Confidential

Grade ____________ Height ____________

Weight ____________

CHARDON LOCAL SCHOOLS

Emergency Medical Authorization

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached. PART I OR PART II must be completed.

PART I: CONSENT

Student Name: ______________________________ School: ______________________________

Address: ______________________________ Phone Number: ______________________________

Residential Parent/Guardian

Mother: ______________________________ Daytime Phone: ______________________________

Father: ______________________________ Daytime Phone: ______________________________

Other Authorized Contact: ______________________________ Daytime Phone: ______________________________

Name of relative or childcare provide:______________________________

Address: ______________________________ Phone: ____________________ Relationship: ____________

In the event reasonable attempts to contact me or those listed above are unsuccessful, I hereby give consent for the following medical care providers and local hospital to be called. I further authorize the administration of any treatment deemed necessary by the preferred doctors, or in the event the preferred practitioner is not available by another licensed physician or dentist, and the transfer of the child to the preferred hospital or any hospital reasonably accessible.

Doctor: ______________________________ Phone: ____________________

Dentist: ______________________________ Phone: ____________________

Medical Specialist: ______________________________ Phone: ____________________

Local Hospital: ______________________________ Phone: ____________________

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: ______________________________

____

____

Date: ____________________ **Parent/Guardian Signature:** ______________________________

PART II: REFUSAL OF CONSENT (DO NOT COMPLETE PART II IF YOU COMPLETED PART I)

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), (to take the following action):

____

____

Date: ____________ **Signature:** ______________________________ **Address:** ______________________________

CHARDON LOCAL SCHOOLS
Athletic Insurance Waiver

Athlete's Name: ______________________________

Sport: ______________________________

To Parents/Guardian:

Some type of health insurance is necessary for your son/daughter to participate in Chardon Local Schools interscholastic athletics.

Please check one of the following and sign below.

_____ My son/daughter is insured for athletic injuries in which we (the parents or legal guardian) subscribe.

Name of company: ______________________________

_____ My son/daughter is **not insured** for athletic injuries. We (the parents or legal guardian) will assume the responsibility for purchasing the insurance necessary to cover any injury occurred during participation in interscholastic athletics.

Forms for school insurance, which will cover such injuries, are available in the High School Student Service Office or in the Middle School Main Office.

Parent/Guardian
Signature: ______________________________ Date: __________