

# Western Reserve High School

3841 U.S Route 20 E., Collins, Ohio 44826, Telephone (419) 668-8470 Fax (419) 663-5916

*"Home of the Rough Riders"*

## Guest Student and Host Student Dance Registration Application

WRHS Student: \_\_\_\_\_ Guest: \_\_\_\_\_

Date of Dance: \_\_\_\_\_ Guest's School: \_\_\_\_\_

1. Guests who do not attend high school and are not an alumnus of Western Reserve High School must have administrative approval.
2. The guest understands he/she must follow all Western Reserve High School policies while attending a school sponsored activity and he/she will accept any discipline in the event WRHS policies are not followed. He/She will have his/her parent sign and his/her home school principal (if a student) sign (indicating the guest is in good standing) the form below.
3. The parent of the guest understands and agrees with the condition placed on the child in section 2 above. The parent of the host understands and agrees with the conditions placed on his/her child in section 5 below.
4. The home school principal of the guest must sign below indicating the guest is not a discipline problem and is in "good standing" at the school named above. (A copy of this application will be mailed to the home school principal).
5. The WRHS student who is hosting the above named guest agrees to be responsible for his/her guest.
6. The form with all required signatures must be turned into the principal of WRHS no later than 2:30 the Friday before the dance.

Signatures Required With Their Agreement Of The Above Terms

Guest \_\_\_\_\_

Guest Home School \_\_\_\_\_ Telephone \_\_\_\_\_

Parent of Guest \_\_\_\_\_

Principal of Guest \_\_\_\_\_

WRHS Student \_\_\_\_\_

Parent of WRHS Student \_\_\_\_\_

## WESTERN RESERVE MIDDLE/HIGH SCHOOL EMERGENCY MEDICAL AUTHORIZATION

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Parents/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ One Call phone number \_\_\_\_\_

**Parent Email :** \_\_\_\_\_ **PSEO/EHOVE Student Email:** \_\_\_\_\_

*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 and returned to school of attendance.*

### PART I – TO GRANT CONSENT

Emergency Contact	Contact Name/Place	Contact Phone Number
Mother/Guardian Daytime		
Father/Guardian Daytime		
Mother/Guardian Cell Phone		
Father/Guardian Cell Phone		
Childcare Provider		
Relative		
Emergency Contact		
Physician		
Dentist		
Hospital Preference		

*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 physician/dentist, 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:* \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Do not complete PART II, if Part I completed 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:* \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If my child is ill and I am unable to transport him/her, my child may be released to:

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_