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_____ Latchkey

CLOVERLEAF LOCAL SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION - Students –2018-2019

S-14 (Rev June 2016)

CHILD'S NAME (Print name) _____
As it appears on the birth certificate (Last) (First) (Middle)

PHYSICAL ADDRESS WHERE CHILD LIVES _____
(Street/Road Number) (City) (Zip)

MAILING ADDRESS (If different) _____
(PO Box Number) (City) (Zip)

HOME PHONE _____ HOME E-MAIL _____

CHILD'S BIRTHDATE _____ Male___ Female____ City of Birth _____

GRADE_____ SCHOOL _____HOMEROOM TEACHER_____ Homeroom #_____

Bus #(AM _____ Shuttle Bus # (AM)_____ Shuttle Bus # (PM)_____ Bus #(PM)_____

WHO HAS LEGAL CUSTODY OF THIS CHILD? _____

STUDENT RESIDES WITH: ___Mother ___Father ___Both ___Grandparent Other/guardian_____

NAME	*RELATIONSHIP*	*PLACE OF WORK*	*WORK PHONE*	*CELL PHONE*	*WORK E-MAIL*

ADDRESS OF OTHER PARENT (If not living with child) _____
(THIS SECTION MUST BE COMPLETED WHEN THERE IS JOINT CUSTODY) Name

_____
Mailing Address City State Zip PHONE NUMBER

☐ CHECK BOX IF A COPY OF CORRESPONDENCE/GRADE CARD SHOULD BE SENT TO THIS PARENT

☐ CHECK BOX IF THIS PARENT SHOULD BE USED AS AN EMERGENCY CONTACT

EMERGENCY CONTACT INFORMATION **First attempt will ALWAYS be the legal parents/guardian.**

If neither parent nor the guardian can be reached, I give permission for you to contact and/or release my child to the following; We will ONLY release your child to the legal parent/guardian and any person indicated below.

NAME	*PHONE*	*CELL*	*RELATIONSHIP*

DAYCARE CONTACT INFORMATION

NAME	*PHONE*	*CELL*	*AM*	*PM*

☐ PLEASE CHECK THIS BOX IF YOUR CHILD WILL ATTEND LATCHKEY AM Location: _____

PM Location: _____

PLEASE COMPLETE ALL INFORMATION ON BACK

Parent/Guardian: **Check one of the boxes below:**

Signature of all legal parents/guardians preferred

☐ I give consent for emergency medical treatment of my child.

☐ I **do not** give consent for emergency medical treatment of my child, but I realize that in the event of serious illness or injury requiring emergency treatment, the school authorities will take reasonable action in the best interest of the child.

_____ _____

Signature of Authorizing Parent/Guardian Date

_____ _____

Signature of Authorizing Parent/Guardian Date

IMPORTANT MEDICAL INFORMATION – PLEASE COMPLETE

I hereby give my consent for the administration of any treatment deemed necessary by:

Preferred Physician: _____

Name **Phone Number**

_____

Address **City** **State** **Zip**

Preferred Dentist: _____

Name **Phone Number**

_____

Address **City** **State** **Zip**

In the event the preferred practitioner is not available, I give consent for treatment by another licensed physician or dentist; and the transfer of the child to

Preferred Hospital: _____

Name **Phone Number**

_____

Address **City** **State** **Zip**

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 CHECK HERE IF MEDICAL INFORMATION BELOW HAS CHANGED**

MEDICAL HISTORY – ALLERGIES – MEDICATION - ETC. (This Section Must Be Completed)

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 check "NONE KNOWN". This information will be shared with appropriate teachers, support staff, and transportation staff who are involved with the student's school day. Please notify the school immediately if there is any change in the student's health history, change in medications or allergies.

_____ NONE KNOWN

ASTHMA_____ DIABETES _____

ALLERGIES_____ SEIZURES _____

ADD/ADHD_____ SKIN _____

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OTHER (specify):_____

_____

_____

_____

☐ PLEASE CHECK THIS BOX IF YOUR CHILD WILL ATTEND LATCHKEY AM Location: _____

PM Location: _____

PLEASE COMPLETE ALL INFORMATION ON BACK