



## EMERGENCY MEDICAL AUTHORIZATION 2011-2012

**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.

|                     |         |          |               |             |
|---------------------|---------|----------|---------------|-------------|
| Student Name (Last) | (First) | (Middle) | Program       | Teacher     |
| Address (Street)    | (City)  | (Zip)    | Date of Birth | Grade       |
| Telephone Number    |         |          | Student ID #  | Home School |

**PART I or PART II MUST BE COMPLETED.**

**PART I (TO GRANT CONSENT)**

In the case of an emergency, I hereby give consent to the following medical care providers and local hospital to be called:

|                           |              |
|---------------------------|--------------|
| Doctor: _____             | Phone: _____ |
| Dentist: _____            | Phone: _____ |
| Medical Specialist: _____ | Phone: _____ |

List any facts and instructions concerning the child's medical history including allergies (severity & medication needs), medications being taken, and any physical impairments to which a physician should be alerted:

**Note: Orders are required for medication to be administrated.**

I would like this information included on a confidential health concern list that would be distributed to school personnel.  
Please circle your response:    Yes    No    Signature of Parent \_\_\_\_\_    Date \_\_\_\_\_

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 physician 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 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

|  |                      |
|--|----------------------|
| Mother's Name: _____                                       | Daytime phone: _____ |
| Cell Phone: _____  | E-mail: _____        |
| Father's Name: _____                                       | Daytime phone: _____ |
| Cell Phone: _____  | E-mail: _____        |
| Other Emergency Contact if Parent Cannot Be Reached: _____ |                      |

**Friend or Relative**

|                |                                  |
|----------------|----------------------------------|
| Name: _____    | Relationship: _____              |
| Address: _____ | Daytime Phone: _____ Other _____ |

**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 no action or to:

\_\_\_\_\_

Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

**INSURANCE**

**If you do not have insurance, please mark none and sign both parent and student.**

\_\_\_\_\_ is insured with \_\_\_\_\_  
Student's Name Name of Company

Policy number \_\_\_\_\_ covering hospital and medical care. We request that our son/daughter be exempt from paying for school insurance for the school year. We assume responsibility for the medical costs due to injury or illness. (If no insurance write none and sign.)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Student Signature

**LORAIN COUNTY JVS  
FIELD TRIP PERMISSION FORM**

Students at the Lorain County JVS are permitted to take school approved trips during the school year. Please read the following before signing.

1. I give my son/daughter permission for school approved educational, competitive, and service field trips taken during the school year.
2. Field trips are an extension of the classroom; therefore, students are expected to follow school regulations as enforced by the instructors and chaperons. Infractions of the regulations will be handled in accordance with the JVS Disciplinary Policy.
3. I understand that for medication to be administered a Medication Administration form must be completed.
4. My signature means that I have read and consented to the above conditions.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Parent's Signature

**PHOTO / VIDEO CONSENT AND RELEASE**

We, the undersigned, (student and parent/guardian if a minor), hereby grant to the Lorain County JVS, the right to use and publish photographs/videos of me, my image, likeness and/or quotes for the purposes of education or promotion (for any social media networks, publicity, advertising, and marketing) of the Lorain County JVS and its related activities.

Additionally, we waive the right to inspect and/or approve the finished product and the use(s) to which it will be applied. Furthermore, we release the Lorain County JVS from any future liability or compensation claims associated with the use of said photographs/videos.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Parent/Guardian Signature