

Office Use Only  
 Copy \_\_\_\_\_ Teacher  
                   \_\_\_\_\_ Transportation  
                   \_\_\_\_\_ Latchkey

**CLOVERLEAF LOCAL SCHOOLS  
 EMERGENCY MEDICAL AUTHORIZATION - Students –2020-2021**

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:**

<b>Name</b>	<b>Phone Number</b>
<b>Address</b>	<b>City</b>
	<b>State</b>
	<b>Zip</b>

**Preferred Dentist:**

<b>Name</b>	<b>Phone Number</b>
<b>Address</b>	<b>City</b>
	<b>State</b>
	<b>Zip</b>

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:**

<b>Name</b>	<b>Phone Number</b>
<b>Address</b>	<b>City</b>
	<b>State</b>
	<b>Zip</b>

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 \_\_\_\_\_

OTHER (specify): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_