

Greene County Career Center
EMERGENCY MEDICAL AUTHORIZATION
STUDENT INFORMATION/PARENTAL PERMISSION FORM
SCHOOL YEAR 2018-2019

Rev 6/2018

1st Year Lab
 2nd Year Lab

To be completed by parent or guardian. PLEASE PRINT

Career Technical Program	Student Name
Partner School	Address
Parent/Guardian Email	City/State/Zip
Birth Date	Home Phone

Student Lives with: _____ **Custody Papers on File?** _____

EMERGENCY CONTACTS

List people the school may contact in the event of accident or illness and those who have authority to make decisions in an emergency. **Parent/guardian names first.** The student may be released to those on this list.

Name	Relationship to Student	Phone Number(s)
	<i>Mother/Guardian</i>	
	<i>Father/Guardian</i>	
	<i>Relative</i>	
	<i>Friend</i>	
	<i>Other</i>	

EMERGENCY MEDICAL AUTHORIZATION

PURPOSE: To enable parents/guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority when parents/guardians cannot be reached.

Part I: TO GRANT CONSENT FOR MEDICAL TREATMENT

I hereby give consent for the following medical care providers to be contacted:

Physician _____	Phone _____
Dentist _____	Phone _____
Medical Specialist _____	Phone _____

In the event reasonable attempts to contact me have not been successful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the above-named doctor(s) or dentist; or, in the event the designated practitioner is not available, by another licensed physician or dentist; and, (2) the transfer of my child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. (See reverse side for important medical history.)

Date _____ **Signature of Parent/Guardian** ← 1

Part II: REFUSAL ONLY: TO CONSENT FOR MEDICAL TREATMENT

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:

Date _____ **Signature of Parent/Guardian**

STUDENT HANDBOOK - CODE OF CONDUCT

I have reviewed the Student Handbook, including Code of Conduct with my student.

Date _____ **Signature of Parent/Guardian** ← 2

Date _____ **Signature of Student** ← 3

I understand that student records shall be maintained and collected in accordance with Board Policy 8330 and State/Federal laws. **Parent/Guardian Signature** ← 4

PLEASE COMPLETE THIS FORM ON THE REVERSE SIDE

PARENTS/STUDENTS NOTE: 11 SIGNATURES ARE REQUIRED TO COMPLETE THIS FORM!

HEALTH SERVICES RECORD

Please complete the following brief health history. All student permanent records, including the health record, remain at the home school. This information is necessary so that we may be aware of any health needs or disabilities. First aid treatment and nursing care in the clinic will be given accordingly. Circle "Yes" or "No."

Any allergies to food?	Yes	No	Any vision/hearing problems?	Yes	No
Medications?	Yes	No	Wears glasses/contacts?	Yes	No
Other (insect, etc.)?	Yes	No	Uses hearing device?	Yes	No
Any physical disabilities?	Yes	No	Any history of serious injury or surgery?	Yes	No
Any chronic conditions such as asthma, diabetes, or seizures?	Yes	No	Is this student a parent?	Yes	No
Any emotional/psychological problems?	Yes	No	Pregnant?	Yes	No
			Any medication being taken at the present time?	Yes	No

Please explain if any of the above questions are marked "Yes". If student is taking medication, please list here. (See Student Handbook for school medication policy.)

I certify that the above information is correct. I give permission for the school nurse to share pertinent information with appropriate school staff, and hospital or emergency personnel.

Date _____ **Signature of Parent/Guardian**

← 5

I am aware that home district schools require proof of student's MCV4 vaccine and will provide copy.

Signature

← 6

FIELD TRIP INFORMED CONSENT

All students are expected to present and conduct themselves in such a manner as to bring credit upon the school and the Career Technical Program which they represent. Any student, who in the judgment of the teacher, parent, chaperone, or driver violates this trust by actions which are detrimental to health, safety, morals, or acceptable decency shall be reprimanded at the discretion of the chaperone. Acts such as drunkenness, immorality, rowdiness, tobacco use, or insubordination shall be cause for the immediate return of the offender to his/her home. If such action becomes necessary, the parents of the offender will be notified; and the offender shall be returned by public carrier at his/her own expense. When necessary, further disciplinary action may be taken by the Director, or his designee, upon the return of the offender. No chaperone (either teacher, parent, or driver) shall be held responsible for any accident incurred on a field trip, assuming that reasonable supervision and precautions have been taken. I, the undersigned, hereby agree to abide by the above conditions for all field trips to be taken as part of the educational process throughout the year.

Date _____ **Signature of Student**

← 7

Date _____ **Signature of Parent/Guardian**

← 8

STUDENT SAFETY AGREEMENT

I agree to observe ALL safety rules and procedures for safe operation and conduct and any others which my teacher will present at a later time during the course of my Career Technical Program. I realize that safety is important, is partially my own responsibility, and that my privilege to use the program laboratory depends upon my developing and demonstrating safe work habits. I have read the STUDENT SAFETY AGREEMENT and I understand that failure to follow these rules and regulations will subject me to disciplinary action by the teacher and/or school administration.

Date _____ **Signature of Student**

← 9

I hereby give my consent to allow my child to operate all machines, tools, and equipment; and, perform procedures necessary in carrying out the curriculum of the Career Preparation Program in which he/she is enrolled.

I have read the STUDENT SAFETY AGREEMENT, designed to protect the health and safety of my child, and agree with the necessity for compliance with these rules. Furthermore I am aware that student accident insurance is available through the Greene County Career Center and that if I choose not to participate in the insurance program, I will be responsible for the expenses of medical and/or dental care as the result of school-related incidents.

Date _____ **Signature of Parent/Guardian**

← 10

Permission to Photograph for District Publications -see website for details: (Circle one and Sign)

Yes **No** **Signature:** _____

← 11