

CLAY HIGH SCHOOL
Emergency Medical Authorization Form
2008-2009

Please check if there is a change of address or other information

STUDENT: _____ STUDENT ID: _____ GRADE: _____

ADDRESS: _____ DATE OF BIRTH: _____

HOME PHONE: _____

MOTHER CONTACT INFORMATION

FATHER CONTACT INFORMATION

EMERGENCY CONTACT

NAME: _____

NAME: _____

CALL 1ST: _____

DAY PHONE: _____

DAY PHONE: _____

RELATIONSHIP: _____

CELL PHONE: _____

CELL PHONE: _____

PHONE: _____

PAGER: _____

PAGER: _____

CALL 2ND: _____

EMPLOYMENT: _____

EMPLOYMENT: _____

RELATIONSHIP: _____

EMAIL ADDRESS: _____

EMAIL ADDRESS: _____

PHONE: _____

Please indicate custodial parent:

Mother & Father Mother Father Guardian

Please list anyone who is NOT PERMITTED to visit/pick up your student from school:

Name: _____

Name: _____

FIELDTRIP PERMISSION AND WAIVER SLIP

By signing this form, we hereby permit _____ to attend those fieldtrips approved by the administration of Clay High School under the supervision of the assigned teacher/advisor. We believe the necessary precautions will be taken. Beyond this we will not hold the school, those supervising the trip, or those driving the bus responsible. We give our consent for _____ to attend these authorized trips.

We further understand that regular school rules and regulations apply to all students while traveling to, attending, and returning from this trip and that failure to follow these rules will result in disciplinary action. These rules include:

1. Use or evidence of use of tobacco, drugs, or alcohol is prohibited.
2. Hands, arms, and head are not to be extended out of the bus window.
3. No offensive language, yelling or excessively loud talking is permitted.
4. All students riding the bus to an event must return on the bus. **NO EXCEPTIONS!**
5. The code of conduct of Clay High School (in Student Handbook) will be followed at all times.

Student Name: _____

Parent / Guardian Signature

Date of Signature

* OVER *

COMPLETE EITHER PART 1 OR PART 2 BUT NOT BOTH

STUDENT NAME: _____

PART 1: I grant consent for treatment to medical care providers and local hospital (PLEASE PROVIDE NAME AND PHONE NUMBER)

PHYSICIAN: _____ DENTIST: _____

PHONE: _____ PHONE: _____

CHILD HEALTH CONDITIONS:

LIST ALL MEDICATIONS YOUR CHILD TAKES

LIST ALL ALLERGIES THAT YOUR CHILD HAS

IN THE EVENT WE ARE UNABLE TO CONTACT A PARENT IN AN EMERGENCY, THE SCHOOL WILL HAVE YOUR CHILD TRANSPORTED BY LOCAL EMS TO THE NEAREST HOSPITAL.

Parent / Guardian Signature

I give my permission for _____'s health information to be shared with school staff and emergency care personnel as needed. YES NO

Parent / Guardian Signature

Date

PART 2: Refusal to consent for treatment to Medical Care Providers and Local Hospital.

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take **ONLY** the following action:

Parent / Guardian Signature