EMERGENCY MEDICAL AUTHORIZATION
LOWELLVILLE K-12 SCHOOL

PLEASE PRINT CLEARLY AND PRESS FIRMLY SO LAST PAGE IS LEGIBLE

CHILD'S NAME _____ Bus No _____
Last First Middle

ADDRESS _____ Phone No _____

CITY/STATE/ZIP _____ Social Security # _____

Age/Date of Birth _____/_____ Grade/Homeroom #_____/_____

PLEASE CONTACT THE FOLLOWING IN CASE OF EMERGENCY "COMPLETE ALL FOUR SPACES" Contact will be made in the order in which they are listed.

1. _____
Name Relationship

_____
Home Phone Business Phone

_____
Cell Phone Pager

2. _____
Name Relationship

_____
Home Phone Business Phone

_____
Cell Phone Pager

3. _____
Name Relationship

_____
Home Phone Business Phone

_____
Cell Phone Pager

4. _____
Name Relationship

_____
Home Phone Business Phone

_____
Cell Phone Pager

5. TO GRANT CONSENT

In the event reasonable attempt to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physicians below or, if they are not available, by another licensed physician or dentist. I give my consent for my child to be transferred to the hospital below, or any hospital reasonably accessible.

This authorization does not cover major surgery unless medical opinions of two other licensed physicians or dentists concerning in the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. _____

_____

_____
Preferred Physician (Phone)

_____
Preferred Dentist (Phone)

_____
Preferred Hospital (Phone)

_____
Signature of Parent or Guardian Date

6. REFUSAL OF CONSENT (Fill out ONLY if you haven't completed No. 5 above)

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

_____

_____

_____
Signature of Parent or Guardian Date

White Nurse's File (1) Copy to the following: Office, Field Trip/Teacher, Bus Driver

LOWELLVILLE LOCAL SCHOOLS

52 Rocket Place, Lowellville, Ohio 44436

Board of Education
Michael Palumbo, President
Brian Wharry, V-President
Gerald Dubos
Joseph Sturm
Stephanie Yon

Administration
Dr. Eugene Thomas, Supt.
Tracie Parry, Principal
Bryan Schiraldi, Treasurer
Lawrence Sammartino, Dean of Students

ROCKETS

Transportation Release

Please complete the following that apply:

(To Event)

I do hereby grant my permission for my child, _____,to be transported to the following extra-curricular activity, _____on (date) _____ by (print name) _____.

(From Event)

I do hereby grant my permission for my child, _____,to be transported home from following extra-curricular activity, _____on (date) _____ by (print name) _____.

_____
Parent Signature

_____
Principal or Athletic Director Signature

_____
Coach or Advisor Signature

This form must be completed and returned to the coach or advisor with ALL signatures BEFORE departure to the event.