MEDICAL FORM FOR THE ACADEMY FOR THE PERFORMING ARTS

School Year	*AUTHORIZATION FORM* **Chagrin Falls Exempted Village Schools**

Last Name	First Name	Middle Name	Grade
Date of Birth	County of Residence	Village or Township	Home Phone

Street Address	Post Office	Zip	Mother Cell Phone Father Cell Phone

Mother/Guardian First and Last Name	Child Lives With	Employer	Daytime Business Phone and/or Pager
Father/Guardian First and Last Name	Child Lives With	Employer	Daytime Business Phone and/or Pager

If a parent or guardian cannot be contacted and it is advisable to send my child home due to minor illness or injury, he/she can be released in the custody of

	Relationship	Phone
1.	Relationship	Phone
2.	Relationship	Phone
3.	Relationship	Phone

EMERGENCY MEDICAL AUTHORIZATION

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.

PART I OR PART II MUST BE COMPLETED.

Part I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and hospital to be called:

PHYSICIAN **PHONE**

DENTIST **PHONE**

LOCAL HOSPITAL

In the event reasonable attempts to contact parent(s)/guardian(s) listed above have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two (2) other licenses physicians or dentists, concurring in the necessity for 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:

DATE **SIGNATURE OF PARENT OR GUARDIAN**

Part II: REFUSAL OF CONSENT (do not complete this part if you completed Part I)

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 OR GUARDIAN**

As a parent or guardian, I give my consent for my child's picture/name to appear on the District Web Page, newspaper, annual report, newsletter, media publications and or via distance learning activities.

☐ Yes ☐ No **Date**___________ **Signature of Parent or Guardian**_______________________________________

E-MAIL CORRESPONDENCE CONSENT AUTHORIZATION

With the understanding that the district cannot assume responsibility for the confidentiality of educational information disclosed through electronic correspondence, I authorize you to correspond via e-mail regarding educational information, including special education needs, to the following address(es):

Name ____________________________ **E-Mail Address** ____

Name ____________________________ **E-Mail Address** ____

Date___________ **Signature of Parent or Guardian**_______________________________________