GRANVILLE SCHOOLS EMERGENCY MEDICAL AUTHORIZATION – Complete and return form before start of school year.

☐ **Check box if your email, address or phone have changed in the past year** Date of Birth

Student Name _____ School and Grade _____

Student Address _____

Parent Address _____

Phone _____ Family E-mail address _____

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, and to authorize listed contacts to pick up students from school reunification site in the event of a long term building evacuation when parents cannot be reached.

Please list, in order of preference, parents, guardians, relatives, or child care providers, that you would like to have contacted in the event of an emergency involving your child.

Parent/Guardian Name _____ Cell Phone _____ Daytime Phone _____

Parent/Guardian Name _____ Cell Phone _____ Daytime Phone _____

Other's Name _____ Relationship _____

Address _____ Phone _____

Other's Name _____ Relationship _____

Address _____ Phone _____

Other's Name _____ Relationship _____

Address _____ Phone _____

Part I or II Must Be Completed

Part I – To Grant Consent

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

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, 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 hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for 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:

_____

_____

_____

Date _____ Signature of Parent/Guardian

Part II – Refusal to Consent

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

Part III Must Be Completed

Part III – Student Handbook and Code of Conduct – found online at www.granvilleschools.org under the Schoology link.

I hereby certify that I have read and understand the student handbook, including the student Code of Conduct:

Date _____ Signature of Parent/Guardian _____

Date _____ Signature of Student _____