

School Year	AUTHORIZATION FORM Chagrin Falls Exempted Village Schools
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Last Name	First Name	Middle Name	Grade
Date of Birth	County of Residence	Village or Township	Home Phone
Street Address		Post Office	Zip
Mother/Guardian First and Last Name		Child Lives With	Employer
Father/Guardian First and Last Name		Child Lives With	Employer

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

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 licensed 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
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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
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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** _____