STUDENT AUTHORIZATION FORM

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, establish early release contacts and establish media authorization.

Student Name: _____Grade _____ M or F B-day _____

School: _____ Teacher/Homeroom:_____ Bus No. _____

Address: _____
Student resides with **(circle all that apply):** Mother, Father, Step-parent, Guardian, Other
Previous school attended:_____ Parent's email:_____
Brothers or Sisters (denote name, building, and grade)_____

If parents are no longer in the same household, please list non-residential parent if said parent has right to student's school information. ***Custody papers must be supplied to school office.***
Non-Residential parent _____ Address _____
Contact Information for those who have authority to make decisions in an emergency or other situation involving this student. (Please list in the order that you would like the school to contact)

1.) Name:_____Relationship to student:_____
_____ _____ _____
1st phone 2nd phone 3rd phone
▢ May also pick-up child for early release
2.) Name:_____Relationship to student:_____
_____ _____ _____
1st phone 2nd phone 3rd phone
▢ May also pick-up child for early release
3.)Name:_____Relationship to student:_____
_____ _____ _____
1st phone 2nd phone 3rd phone
▢ May also pick-up child for early release

EARLY RELEASE

Because the school is responsible for the safety and well-being of your child, s/he will be released, prior to the end of the school day or at the end of the school day, only to a parent or an individual listed below authorized in writing by a parent/guardian.

NAME(s) of AUTHORIZED INDIVIDUALS	**RELATIONSHIP**	**PHONE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

The persons whose names appear above may authorize the release of my child from school.

_____ _____

Parent Signature(s) **Date**

MEDIA AUTHORIZATION

I hereby authorize the Kenton City School District (the "District") to publish and use, and to license others to publish and use, in original or edited form, in connection with school programs and activities my child's photograph, name, likeness, and voice and all work created or produced by my child in newspapers, magazines, the District's video media, and on the District's web page (including all associated staff/department based Web pages). Public performances (sporting events, theatrical, music/orchestra/choir, award events, etc.) are "public" in nature and therefore participants should have NO EXPECTATION OF PRIVACY.

Should I choose to revoke this authorization, I will contact my child's building Principal in writing.

_____ _____

Parent Signature(s) **Date**

EMERGENCY MEDICAL CONSENT FORM

PART I OR II MUST BE COMPLETED

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

_____

_____

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: _____ Date of Last Tetanus: _____

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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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: _____

R.C. 3313.72