COLUMBIANA COUNTY EDUCATIONAL SERVICE CENTER
38720 Saltwell Road Lisbon, Ohio 44432

EMERGENCY TRANSPORTATION AUTHORIZATION
2018-2019

Name of Child/Children*		
Address		Phone
Mother's (or guardian's) name	Address	Phone
Employer's Name	Address	Phone
Father's (or guardian's) name	Address	Phone
Employer's Name	Address	Phone

* Names of additional children from the same family may be listed here when all other information on this form pertains to all children listed.

If not at home or work, provide telephone number where parents can be reached:

Mother (Guardian) ____________________ Father (Guardian)__________________________

People to be contacted in the event of an emergency:

Name	Name
Address	Address
City, State, Zip	City, State, Zip
Relationship to Child	Relationship to Child
Phone:	Phone:

Name of Physician	Name of Dentist or Clinic
Address	Address
City, State, Zip	City, State, Zip
Phone:	Phone:

(CONTINUED ON BACK OF PAGE)

Complete either Part I <u>or</u> Part II below.
DO NOT COMPLETE BOTH

PART I. PERMISSION TO TRANSPORT CHILD

I give ____ (Name of School Program) my permission to transport my child/children ____(Name of Child/Children) to ____ (Hospital/clinic) for emergency care or to ____(Dentist/clinic) for emergency dental care, or to the nearest available source of assistance.

____ ____________________________
Parent's Signature Date

PART II. REFUSAL TO GRANT PERMISSION

I do not give permission to ______________________________________ (Name of School Program) to transport my child/children ____________________________________ (Name of Child/Children) for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken:___________________________

____ ____________________________
Parent's Signature Date

PLEASE LIST ANY FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:_____________________________________

____

AUTHORIZATION FOR PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE PRESCRIBED MEDICATIONS OR TO RECEIVE TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

______________________________	______________________________
Name of Student	Address
______________________________	______________________________
School	Grade

A. I am requesting permission for my child named above to: (Check all that apply)

_____ use or receive prescribed medication

_____ receive prescribed treatment

_____ self-administer prescribed medication(s) in my presence or that of an authorized staff member

in accordance with the Doctor's prescription.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

______________________________	______________________________
Signature of Parent	Date
______________________________	______________________________
Home Telephone	Work Telephone

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PHYSICIAN STATEMENT

To the Physician:

The School District requires that all of the following information be provided before it will administer medication or treatment to the student.

____ ______________________________
Name of Student Address

____ ______________________________
School Class/Grade

I have prescribed the following medication ____

Beginning Date ____________________________ Ending Date ______________________________

Dosage, instructions, or precautions: ___________________________

Report the following side effects to my office immediately ____________________________________

Physician's Signature ____ Telephone _______________

Printed/Typed Name ________________________________ Date ____________________________

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

____
Principal

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CHILD'S HEALTH INFORMATION FORM

2018-2019

Rule 3301-37-05 of the Administrative Code requires preschool programs to secure health information from a child's parent no later than the first day of attendance unless otherwise indicated.

Name of Child (print or type)	Date of Birth	Name of Parent/Guardian
	Height	Weight

1. Allergies (list all allergies affecting the child and any special precautions or treatments indicated for these allergies:____
____
____

2. Medications, food supplements, modified diet, or fluoride supplements (list all medications currently being administered to the child.)____
____
____

3. Chronic Physical Problems (List all chronic physical problems affecting the child.)_________
____
____

4. History of Hospitalization (List dates of all hospitalizations of the child.)__________________
____
____

5. Diseases (List all diseases the child has had.)______________________________________
____
____

6. Immunizations (enter month/day/year of each immunization)

   DTP: 1________ 2_________ 3_________ 4_________ 5_________

   Polio: 1________ 2_________ 3_________ 4_________ 5_________
   Measles, mumps, rubella--usually combined as MMR 1_________ 2_________

   Hepatitis B: 1__________ 2___________ 3__________

   HIB: 1__________ 2___________ 3__________

   Varicella: __

____

**The 5th DTP and 4th polio should be administered just prior to preschool or school entrance.

Name of Person Completing This Form:	Date:

COLUMBIANA COUNTY EDUCATIONAL SERVICE CENTER
FIELD TRIP/ COMMUNITY VISIT CONSENT FORM
2018-2019

I hereby give permission to ____ to attend all
(student's name)
field trips/ community visits sponsored by the Columbiana County Educational Service Center for the upcoming school year.

I will not hold the organization sponsoring these trips or the Columbiana County Educational Service Center in any way responsible for anything that may occur in connection with these trips. I understand, however, that the group is being properly chaperoned and every precaution is made to prevent accidents.

___________________________________ ___________________________________
Date Parent or Guardian

COLUMBIANA COUNTY EDUCATIONAL SERVICE CENTER

PHOTO INFORMATION CONSENT FORM
2017-2018

I (We) hereby give permission to the Columbiana County Educational Service Center and the news media to photograph, video tape, print, reproduce, duplicate and/or distribute pictures of my (our) son/daughter___________________________________.

It is understood that such pictures may appear in publications and/or other media presentations of the Columbiana County Educational Service Center as well as newspapers of general circulation, and that such pictures will only be used to inform others about programs offered and services performed by the Columbiana County Educational Service Center.

(Indicate your decision by a check mark and then your signature.)

☐ I **do** give my permission for use of pictures.

☐ I **do not** give my permission for use of pictures.

_____________________________________ _____________________________________
Parent/Guardian Signature Date

_____________________________________ _____________________________________
Parent/Guardian Signature Date