**CEVEC/CLSP**

### Please Print STUDENT MEDICAL HISTORY 2014- 2015

Student Name: District/Residence:

Student Address: District/Placement:

City & Zip: School Phone:

Date of Birth: Family Physician:

Student Soc. Sec. #: Physician Phone:

Home Phone: Guardian Name:

Parents Name: Guardian Address:

Father Work #: Guardian Phone #:

Mother Work #: Pager or Cell Phone #:

Student Cell Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an emergency list two people who can be contacted if parents can't be reached:

Name Phone Address

1.

2.

If (s)he has a history of any of the following, please check appropriate space:

\_\_\_\_\_\_Allergies: explain: \_\_\_\_\_\_Dizziness: explain:

\_\_\_\_\_\_Heart Problems: explain: Asthma: treatment:

\_\_\_\_\_\_Seizure Disorder: explain:

\_\_\_\_\_\_Diabetes: treatment:

\_\_\_\_\_\_Hearing Problems: explain:

\_\_\_\_\_\_Speech Problems: explain:

\_\_\_\_\_\_Vision Problems: explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_Glasses: \_\_\_\_\_\_\_Contacts

\_\_\_\_\_\_Medications:

*Name of Drug Dosage Times Dispensed*

\_\_\_\_\_\_Therapy: types currently receiving:

\_\_\_\_\_\_\_Occupational \_\_\_\_\_\_\_Physical \_\_\_\_\_\_\_Psychotherapy \_\_\_\_\_\_\_Counseling

\_\_\_\_\_\_\_Other: explain:

\_\_\_\_\_\_Attendant care for personal needs: explain:

\_\_\_\_\_\_Adaptive devices:

\_\_\_\_\_\_\_Wheel Chair \_\_\_\_\_\_\_Braces \_\_\_\_\_\_\_Cane/Walker

\_\_\_\_\_\_Medical Limitations: explain:   
\_\_\_\_\_\_Seizures: explain:

\_\_\_\_\_\_\_Generalized \_\_\_\_\_\_\_Tonic clonic \_\_\_\_\_\_\_Absence

\_\_\_\_\_\_Other Health Problems: Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_

My child is covered by: \_\_\_\_\_\_\_

Insurance Plan *(required information for student to attend community training)* Policy Number

*PURPOSE:* *To enable parents or guardians to authorize the provision of emergency treatment for a student who*

*becomes ill or injured while under school authority, while parents or guardians cannot be reached.*

# Group Training Site/Community Living Skills Program Consent

I give my son/daughter permission to participate in the community group training site experience and to be transported by school transportation. The following are possible alternatives for transportation to and from group sites for your son/daughter: by school bus, by CEVEC staff member in CEVEC van, walk /by CEVEC staff person for purpose of job exploration, or interview, travel training, walk from CEVEC to group training site.

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent /Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The staff at CEVEC is very interested in providing a safe valuable experience in the community for your son/daughter. If you have any questions at all, please feel free to call and discuss your concerns.

**Signature required on back Please turn over 🠞**

## Medical Consent *PART I OR PART II MUST BE COMPLETED.*

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred physician) or

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the student to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE SIGNATURE OF PARENT/GUARDIAN

***DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I***

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action to:

DATE SIGNATURE OF PARENT/GUARDIAN

**MAYFIELD CITY SCHOOL DISTRICT**

**MEDIA RELEASE**

I, the parent/legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, grade \_\_\_\_\_\_, grant the Mayfield City School District permission to use my child’s name, visual images, artwork and/or comments in all Mayfield City School District publicity materials. In granting permission, I understand that the images and comments may appear in a variety of forms, including, but not limited to magazines, newspapers, books, brochures, newsletters, television, videotape, advertisements, photographs, web sites, and media sources. I agree that the use of my child’s visual images and/or reproduced art work shall become the exclusive property of the Mayfield City School District, and I waive all rights thereto. I waive all rights to inspect and/or approve copy or voice-over commentary that may be used in conjunction with the visual images and the uses to which they may be applied.

Parent/legal guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/legal guardian Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check One

**Permission Granted: ❑ Permission denied: ❑**

**THIS AGREEMENT SHALL REMAIN IN EFFECT FOR THE 2014-2015 SCHOOL YEAR AND SHALL BECOME NULL AND VOID AT THE START OF THE 2015-2016 SCHOOL YEAR.**