

**Combined Parent Permission & Emergency Medical Authorization**

Extracurricular, Co-curricular and Athletics

Permission Section (both the permission section and EMA require signatures)

Event/Activity: \_\_\_\_\_ Date: \_\_\_\_\_

**Permission** - This permission slip is for participation in the above referenced activity. This activity will be supervised by the Mason City Schools staff.

We, the undersigned do hereby give permission for our child to participate in the above stated activity. We do hereby assume full responsibility for any risk of bodily injury, personal injury or mental injury or death due to our child's participation in these activities and the necessary travel to and from any activity site. We also further hereby assume full responsibility for all lost, stolen, or damaged personal property and will not hold the school or its employees responsible for said loss or damage to personal property.

The undersigned further release, waive, discharge and covenant not to sue the Mason City School District Board of Education, its individual members, its superintendent, principals, administrators, employees, agents or anyone acting on its behalf, from all liability, arising from or by reason of any bodily injury, personal injury or mental injury, known or unknown, including death, resulting from, or to result from our child's participation in field trips and co-curricular activities with Mason City School District.

We expressly agree that this release is intended to be as broad and inclusive as permitted by the laws of the State of Ohio or any other state in which said student may be injured and that if any portion of this release is held invalid, it is agreed that the balance shall, nevertheless, continue in full force and effect. We further state that we have fully and carefully read the above release and know the contents of the same and sign this release as our own free act. We further consent to emergency treatment by a physician in the event of injury to or illness of our child during his/her participation in such activities.

\_\_\_\_\_  
Date Signature of Parent/Guardian

EMA - Section

**EMERGENCY MEDICAL AUTHORIZATION**

MCS - 201 Rev 12/10

**Student Information:**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: Teacher/Team: \_\_\_\_\_

Mother: Phone: \_\_\_\_\_ (day/night): Cell: \_\_\_\_\_ Father: Phone: \_\_\_\_\_ (day/night): Cell: \_\_\_\_\_  
(Circle one) (Circle one)

**Is there a legal custody order that applies to this child?** Yes or No

If yes, please submit a copy of the final custody/guardianship papers to the district registrar or the guidance department in your child's building.

**Emergency Contacts** (if parent/guardian cannot be reached):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: Cell: \_\_\_\_\_

**Emergency Care Information:**

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

(Alternate hospital may be selected at the discretion of the responding Emergency Medical Services personnel)

Allergies and/or Specific Health Considerations: \_\_\_\_\_

Medications taken by student on a daily or frequent basis: \_\_\_\_\_

**PLEASE SIGN ONLY ONE OF THE FOLLOWING PARENT/GUARDIAN SIGNATURE LINES:**

**PART I - TO GRANT CONSENT**

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: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**Student Signature** (If 18 years or older) \_\_\_\_\_

**PART II - REFUSAL TO CONSENT**

(Complete only if action described above is refused)

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: \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**Student Signature** (If 18 years or older) \_\_\_\_\_