Foxfire Schools Emergency Medical Authorization Form

Student Name:____________________ Parent/Guardian Name:____________________

Address:____________________ Home Phone #:____________________

City:__________ State:____ Zip Code:______ Cell Phone #:____________________

Student SS#:____________________ Parent SS#:____________________

Grade:__________ Birthdate:__________ Mother's Maiden Name:____________________

Male or Female____ __Race:__________ City of Birth:____________________

District of Residence:____________________ SSID#____________________

Parent E-Mail address

Emergency Contacts

1.____________________PH #________________Relationship______________

2.____________________PH #________________Relationship______________

3.____________________PH #________________Relationship______________

Facts concerning the child's medical history including allergies, medications and any physical impairments:

Allergies:______________________________Date of Last Tetanus Shot:______________

Medications being taken:____

Physical Impairments:____

Part I: To Grant Consent

I hereby give consent, in the event reasonable attempts to contact me have been unsuccessful, for the administration of any medical treatment deemed necessary by any licensed physician, dentist, or eye doctor; and the transfer of my child to any hospital reasonable 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.)

Date:______________ Parent/Guardian Signature:______________________________

Do Not Complete PART II if you completed PART I

Part II: Refusal to Consent: I do NOT give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action.

Date:______________ Parent/Guardian Signature:______________________________

Foxfire Schools

General Parent Permission Form

Student Name____

In a an effort to provide students and their families with the best educational environment possible, Foxfire staff attempts to meet individual needs (academic, social, emotional, post-secondary) in a flexible student centered manner. Foxfire continually builds relationships with community agencies that offer free and lost services to our students. At times, these opportunities arise quickly and we many have trouble contacting parent/guardians for permission.

Please review this form carefully and mark your preferences and sign the bottom so that Foxfire staff knows your wishes ahead of time.

1. My student may be given over the counter medications: such as Tylenol, Advil, antacids, throat lozenges, etc. **Yes No**

2. Should it become available, my student may receive information and or samples of birth control devices (along with abstinences information). **Yes No**

3. My student may receive emergency transportation from Foxfire staff. **Yes No**

4. My student may participate on field trips. **Yes No**

Parent/Guardian Signature____Date:__________________

***I grant permission for Foxfire School's to use my child's picture in the district reports, calendars, annuals, booklets, videos, digital media, etc., including the use of my name or no name, for the purpose of publicity or advertising for the school district.**

Parent Signature____Date:__________________

I do **not give my permission for my student's picture to be used.

Parent Signature____Date:_________________