



## Parade of Graduates Permission Form

Dear Senior Parents and Guardians,

On Monday May 20<sup>th</sup> 2019, Lakota will be hosting the Lakota Parade of Graduates for its third year.

Seniors from East and West High Schools will be bussed using Lakota buses to return to their elementary school, or to the school they have been assigned to.

I give permission for my student to participate in, and to ride the bus, for the Lakota Parade of Graduates event. If my child has specific medical needs, I have included them on the Emergency Medical Form on the back of this permission slip.

### Student Information:

\_\_\_\_\_

First

\_\_\_\_\_

Last name

\_\_\_\_\_

Student ID#

### Please circle elementary school:

Adena

Cherokee

Endeavor

Freedom

Heritage

I did not attend Lakota grades 3-6

### If you did not attend Lakota grades 3-6

I would like to go to \_\_\_\_\_ **OR** place me where I am needed

<http://www.wlwt.com/article/lakota-seniors-take-part-in-parade-of-graduates/20137403>

By signing this form, I release Lakota Local Schools from any potential liability issues.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

\*please complete Emergency Medical Form on the reverse side\*

Office Use Only: Spreadsheet:



EMERGENCY MEDICAL AUTHORIZATION

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. Please use Blue or Black Ink.

Student Name Student ID Male Female
Address Zip School
Home Phone DOB Grade Homeroom

Father's Name Cell/Work
Address (if different from student) Home Phone
Email Address Work Phone
Step-Mother's Name Cell/Work

Mother's Name Cell/Work
Address (if different from student) Home Phone
Email Address Work Phone
Step-Father's Name Cell/Work

Guardian's Name Cell/Work
(if other than parents)
Email Address Work Phone

Person(s) who may be notified and to whom your child may be released if school cannot reach you:

- 1. Relationship Phone
2. Relationship Phone
3. Relationship Phone

Facts concerning the child's medical history including allergies, medications taken on a daily or frequent basis, and any physical impairments to which a physician should be alerted: (Health alerts related to dietary concerns must be communicated directly to Lakota Local School Office of Child Nutrition: 6947 Yankee Rd., Liberty Township, OH 45044 (513) 644-1163, by the parent or guardian.)

The Registered Nurse may share health information with appropriate school personnel to aid in present and future educational decisions.

Doctor to be called Phone
Dentist to be called Phone
Preferred local hospital

Part 1-TO GRANT CONSENT Please sign either Part 1 or Part 2 but not both

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 reasonable accessible. This authorization does not cover major surgery unless the medical opinion of two 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 2-TO REFUSE 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 NO action or to:

Date Signature of Custodial Parent/Guardian