East Liverpool Christian School
46682 FLORENCE STREET EAST LIVERPOOL, OHIO 43920
PHONE: [330]385.5588 FAX: [330]385.1267

EMERGENCY TRANSPORTATION AUTHORIZATION 2018-2019

Name of Child		
Address		Phone
Mother's Name	Address	Cell Phone
Employer's Name	Address	Phone
Father's Name	Address	Cell Phone
Employer's Name	Address	Phone

People to be contacted in the event of an emergency if the parent cannot be reached:

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

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

Date of last physical exam:_____

Medications (prescriptions or over the counter) child is currently receiving. Please list the dosage, times of day medication is usually given and the reason for the medication.

_____

_____

Any known allergies _____

_____

Special precautions and/or treatments for allergies _____

_____

Chronic physical problems affecting child: _____

_____

Any other information the school should be aware of: _____

_____

This Information was provided by (please print): _____

Signature of parent or guardian: _____ Date: _____

Complete either Part I or Part II below. Do not complete both.

Part I. Permission to transport child

I give East Liverpool Christian School permission to transport my child to

_____
Hospital/Clinic

for emergency care or to _____ for emergency dental care,
Dentist/Clinic

or to the nearest available source of assistance.

_____ _____

Parent's Signature Date

Part II. Refusal to grant permission

I do not give permission to East Liverpool Christian School to transport my child 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