

# Community Service Program

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Edge Teen Center authority when parent or guardians cannot be reached.

**Please use Blue or Black ink**

**Sex** M or F **Student ID** \_\_\_\_\_ **Student Name** \_\_\_\_\_  
**Student Address** \_\_\_\_\_ **Zip** \_\_\_\_\_  
Home Phone \_\_\_\_\_ **Grade** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
School \_\_\_\_\_ **Homeroom #** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
Address (if different than student) \_\_\_\_\_  
E-mail address \_\_\_\_\_ **Cell/Pgr** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
Address (if different than student) \_\_\_\_\_  
E-mail address \_\_\_\_\_ **Cell/Pgr** \_\_\_\_\_

**Guardian's Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_  
**(if other than parents)**  
E-mail address \_\_\_\_\_ **Cell/Pgr** \_\_\_\_\_

**Person(s) who may be notified and to whom your child may be released if Edge Teen Center cannot reach you.**

1. \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_
2. \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_
3. \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Allergies and/or specific health consideration** \_\_\_\_\_  
**Medication taken by student on a daily or frequent basis** \_\_\_\_\_

Doctor to be called \_\_\_\_\_ **Phone number** \_\_\_\_\_  
Dentist to be called \_\_\_\_\_ **Phone number** \_\_\_\_\_  
Preferred local hospital \_\_\_\_\_ **Phone number** \_\_\_\_\_

## **PART 1-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 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 Edge Teen Center authorities to take NO action or to:

\_\_\_\_\_

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