AP TESTING CONSENT FORM

For the safety of your child we would appreciate your filling in the following blanks pertaining to emergency information.

My child _____ has my permission to participate in AP Testing on
(Name)

_____, at New Hope Baptist Church (1401 Loveland Madeira Rd., Loveland, OH 45140.
(Date/s)

This form must be returned to Mrs. Mahan in the Office of School Counseling by Friday, February 12.

THE INFORMATION BELOW MUST BE COMPLETED

YOUR CHILD WILL NOT BE PERMITTED TO ATTEND AP TESTING UNLESS THIS FORM IS COMPLETED AND RETURNED TO SCHOOL.

PURPOSE: To enable parents & 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.

PART I OR PART II MUST BE COMPLETED.

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me or other parent at the phone numbers listed are unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by family doctor or dentist if preferred is unavailable.
2. The transfer of the child to preferred hospital listed or any other 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.

SPECIAL MEDICAL PROBLEMS & ALLERGIES: _____

_____

PHONE NUMBER WHERE YOU CAN BE REACED ON DAY OF TRIP: _____

Doctor: _____ Dentist: _____

Hospital: _____

Signature of Parent or Guardian: _____Date: _____

Address: _____ Phone: _____

PART II - REFUSAL TO CONSENT

I do **not** give 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 _____

Signature of Parent or Guardian: _____Date: _____

Address: _____ Phone: _____