U.S. Grant CTPD Student/Teacher Release

VIDEO/PUBLICATION RELEASE

I agree without further obligation to me, to allow the use of either my name and/or my child's name, school building name, voice, and/or photography by the U.S. Grant CTPD for educational purposes in connection with the district website, district publications, and for on-air and other promotional purposes for the District.

I agree to allow images for educational purposes of myself and/or my child created through photography, videography or other electronic means in which I appear to be edited, reproduced and distributed for unlimited use, in whole or in part, by U.S. Grant CTPD for district publications and promotional purposes.

I afford U.S. Grant CTPD the royalty-free right to use, reproduce, publish, distribute, perform, and display all material, information, communication, text, graphics, links, electronic art, animation, audio, video, photos, and other data made pursuant to this Release for educational purposes and/or promotional purposes.

In signing this Release, I fully acknowledge and represent that I have read this Release, that I understand the significance of this Release, and I am signing this Release voluntarily as my own free act and deed. I further acknowledge and represent that no oral representations, statements, or inducements, apart from the forgoing written Release have been made.

Dated: _____

_____
Student Name (Please print)

_____
Student Signature

_____
Parent Name

_____
Parent Signature

Address: _____

_____

Deters, Ennis & Roberts
Updated 8/5/15

EMERGENCY MEDICAL AUTHORIZATION

U.S. GRANT CAREER CENTER

STUDENT'S NAME _____ ADDRESS _____

TELEPHONE NUMBER _____ VOCATIONAL PROGRAM _____ HOME SCHOOL _____

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.

A. Residential Parent or Guardian

Mother's Name _____ Mother's Daytime Phone # _____

Father's Name _____ Father's Daytime Phone # _____

Other Name _____ Other Daytime Phone # _____

B. Name of Relative or Childcare Provider

Name _____ Relationship _____

Address _____

Phone Number _____

(PART I OR II MUST BE COMPLETED)
PART I TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor's Name _____ Phone Number _____
Dentist's Name _____ Phone Number _____
Medical Specialist Name _____ Phone Number _____
Local Hospital _____ Emergency Room Phone # _____

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 practioner 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 opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be altered:

_____

Date: _____ _____ _____
Signature of Parent/Guardian Address

_____

(DO NOT COMPLETE PART II IF YOU COMPLETED PART I)
PART II REFUSAL TO 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 the following action: _____

_____

Date: _____ _____ _____
Signature of Parent/Guardian Address

_____

(Revised July 2007)
EC/KK/JK