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Horizon Science Academy Columbus

# Medical Consent

Managed By CONCEPT SCHOOLS

**Emergency Medical Authorization Purpose:**

This form is to enable parents and guardians to authorize the provision of emergency treatment for the child who gets ill or injured within the school authority when they are inaccessible.

| | | | | | |
|---|---|---|---|---|---|
| Student's Full Name: | | Birth Date: (mm,dd,yy) | | Grade: | |
| Home Address: | | City: | | State: | Zip: |
| Student Resides With: (*Please Mark*) | Mother | Father | Sibling | Guardian | Grandparent / Stepparent |
| Parent or Guardian's Phones: | _____-_____-_____ | Work: | _____-_____-_____ | | |

**Please Choose One of the Following:**

**A. Consent For Treatment**

| | | | |
|---|---|---|---|
| Preferred Physician's Name: | | Phone: | |
| Preferred Dentist's Name: | | Phone: | |
| Medical Specialist's Name: | | Phone: | |
| Preferred Hospital: | | 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 the preferred doctor indicated, 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 opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**B. 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 the following actions:(*Please Specify Below*)

Parent or Guardian's Signature: Date: (mm,dd,yy)

**Medical History**

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments of which a physician/ school personnel should be informed: (*Please Specify Below*)

Home Address: City: State: Zip:

Parent or Guardian's Signature: Date: (mm,dd,yy)


**Horizon Science Academy** info@horizoncolumbus.org

2350 Morse Road Columbus, OH 43229 Phone: (614) 428-6564 Fax: (614) 428-6574

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# Horizon Science Academy Columbus
# Request for Records

Managed By CONCEPT SCHOOLS

**Permission to Release Permanent School Records**

I, _____, do attest that I am the parent/legal guardian of,
Please Print

_____ whose date of birth is _____
Please Print Date of Birth

As of _____, I have withdrawn my student from _____
mm,dd,yy School Name

and give permission to the principal or the principal's designee to release my student's permanent school records to:

IRN:009179

Horizon Science Academy Columbus 2350 Morse Road Columbus, OH 43229
Phone: (614) 428-6564 Fax: 614) 428-6574

**Attn: RECORDS**

Please send the all of the information listed below, if applicable:

- Grades & Academic Records
- Psychological Assessment & Records
- Disciplinary Records
- Attendance Records
- Medical/Immunization Records
- All Testing Results and/or Evaluations
- All Special Education Records/Info (IEP, MFE, Parent Permission, Prior Written Notice, etc.)

| 1st Request: | 2nd Request: | 3rd Request: |
|---|---|---|
| Date: | Date: | Date: |
| mm,dd,yy | mm,dd,yy | mm,dd,yy |

The student's first day of attendance at Horizon Science Academy will be on: _____
mm,dd,yy

**Parent or Guardian's Signature:** _____ Date: (mm,dd,yy) _____