Parent Approval and Applicant Commitment

Parent approval is mandatory in order to participate in Leadership Ashtabula County. **A signed approval must be received by Leadership Ashtabula County via mail or email.**

Address Leadership Ashtabula County
Attn: Kelli Jones
P.O. Box 643
Ashtabula, Ohio 44005

Email kelli@leadershipac.org

Parent Approval

As the parent or guardian of the student applicant, I have read the Leadership Ashtabula County materials and application with my daughter or son. She/he has my permission to proceed with the application process and, if accepted, has my permission to participate in the program.

Signature: _____
Printed Name: _____
Date: _____

Applicant Commitment

If selected, I agree to attend all program days, complete assignments and to fully participate in the program.

Signature: _____
Printed Name: _____
Date: _____

YOUth LEADERship Ashtabula County

EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME: _____ BIRTH DATE: _____

ADDRESS: _____ TELEPHONE: _____

SCHOOL DISTRICT: _____ SCHOOL ATTENDED: _____

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.

PART I OR II MUST BE COMPLETED

PART I
TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone number) or_____(other parent or guardian) at _____(phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr._____ (preferred dentist), or, in the event the designate preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to _____(preferred hospital) or 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 alerted:

_____

_____

_____

_____ _____
Date Signature of Parent or 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 no action or to:

_____

_____

_____

_____ _____
Date Signature of Parent or Guardian

_____
Address

School Approval

School approval is mandatory in order to participate in Leadership Ashtabula County. **A signed approval must be received by Leadership Ashtabula County via mail or email.**

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P.O. Box 643
Ashtabula, Ohio 44005

Email kelli@leadershipac.org

Student Applicant: _____

As the Principal or Vice Principal of _____, I approve of and recommend the student named above to participate in Youth Leadership Ashtabula County in the 2024-25 school year.

The student applicant's grade point average is _____. Applicant's GPA is not a factor in acceptance, rather it is included in our measures of diversity.

Any additional comments regarding the student applicant:

Signature: _____
Printed Name: _____

Contact (email or phone):_____

Date: _____