



**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](mailto: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: \_\_\_\_\_

**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

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**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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                    Attn: Kelli Jones  
                    P.O. Box 643  
                    Ashtabula, Ohio 44005

**Email**            [kelli@leadershipac.org](mailto: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 2020-21 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: \_\_\_\_\_