Cleveland Municipal School District

STUDENT EMERGENCY FORM

Date _____ Room _____ Teacher _____

(Return to School Office)

Student's Name: _____

Birth Date: ☐☐/☐☐/☐☐☐☐ *(month / day / year)* Sex: ☐ Male ☐ Female Grade _____

Home Address: _____ Zip _____

Parent/Guardian Name: _____ Relationship _____

Phone #s: Home: _____ Cell : _____ Work: _____

Child lives with: ☐ Mother ☐ Father ☐ Caregiver/Guardian ☐ Other _____

Email address: _____

HEALTH CONDITIONS: *(check box)*

☐ Asthma ☐ Bee Sting Allergy

☐ Diabetes ☐ Seizures

☐ Food/Medication Allergy *(please list)* _____

☐ Other *(please explain)* _____

Other children/siblings at this school: *(list name and grade)*

1. _____
2. _____
3. _____

EMERGENCY CONTACT NUMBERS: In case of emergency, illness, or accident to the child named above, the school is authorized to process as indicated.

Contact #1: Name: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

Contact #2: Name: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

Contact #3: Name: _____ Relationship to student: _____

Address: *(If different from home above)* _____ Phone: *(home, work, cell)* _____

My child should **never** be released to the following: _____

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

_____ _____

Signature of Parent/Guardian Date

Cleveland Municipal School District

EMERGENCY DATA FORM

Cleveland Municipal School District

Student's Name: _____

Address: _____ Phone Number: _____

School: _____ Room: _____

The following is required by Section 3313.712 of the Ohio Revised Code.

EMERGENCY MEDICAL AUTHORIZATION

Purpose – to enable parents and guardian 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.

ALL BLANK SPACES MUST BE FILLED IN

In the event reasonable attempts to contact me at _____ *(phone)* or _____ *(other parent)* at _____ *(phone)* have been unsuccessful school personnel will call 911.

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS to which a physician should be alerted.

_____

_____

_____

_____

Family Physicians: _____ Address: _____ Phone: _____

_____ _____

Signature of Parent or Guardian Date

Cleveland Metropolitan School District

Handbook Issuance & Orientation Verification

William Cullen Bryant _____ _____
School Homeroom

_____ _____
Student Name (printed) ID Number

This is to certify that I have received a copy of the Student Handbook-Rights and Responsibilities (revised August, 2005.)

_____ _____
Date Received Student's Signature

Issued by:

___Homeroom Teacher ___ All School Assembly
___Counselor ___ Unit Assembly
___Administrator ___ Homeroom
___ Individual Conference

Insert into permanent record card

CLEVELAND METROPOLITAN SCHOOL DISTRICT

Media/IVR Consent Form

(Check the Applicable Box) **RETURN THIS FORM TO YOUR CHILD'S SCHOOL**

☐ I hereby irrevocably consent to the unrestricted photographing, videotaping otherwise recording or broadcasting or publishing and other unrestricted use of my child's writing, photographs, video, image or likeness, or quotes without limit, reservation or remuneration by the media and/or the Cleveland Metropolitan School District (CMSD). CMSD shall be the sole and exclusive owner of all rights to the said recordings it has taken. I release all rights in the said recordings on behalf of myself and my ward/child.

☐ I do not consent to the photographing, videotaping or otherwise recording or broadcasting or publishing and other use of my child's writing, photographs, video, image or likeness, or quotes by the media and/or the Cleveland Metropolitan School District.

☐ I do not consent to receiving IVR (Interactive Voice Response) messages to my home or emergency phone numbers at any time including notifications of school-related emergencies.

STUDENT INFORMATION

Student Name _____
School ___William Cullen Bryant_____ Grade _____
Parent/Guardian Signature _____
Parent Printed Name: _____
Home Address: _____
Home Phone: _____
Cell Phone: _____
Date _____

* **Disclaimer:** As a matter of policy, the Cleveland Metropolitan School District will not publish both a student's name and photograph together.
* Students over the age of 18 do not need to obtain parental consent.

The goal of the Cleveland Metropolitan School District is to become a premier school district in the United States of America.

☐ **Yes**, my child has an IEP, Individualized Educational Plan.
☐ **No**, my child does NOT have an IEP, Individualized Educational Plan.

☐ **Yes**, my child has a 504 Plan.
☐ **No**, my child does NOT have a 504 Plan.

☐ **Yes**, my child needs to take medicine at school and I will complete the separate consent form.
☐ **No**, my child does NOT need to take medicine at school.