CLEVELAND METROPOLITAN SCHOOL DISTRICT
Vision to Victory

STUDENT EMERGENCY FORM

(Return to School Office)

Date _____ Room _____ Teacher _____

Student's Name: _____

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

Home Address: _____

Parent/Guardian Name: _____ Relationship _____

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

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

Language spoken at home: _____

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)* _____

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 Metropolitan School District

EMERGENCY DATA FORM

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 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.

ALL BLANKS MUST BE COMPLETED

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