



STUDENT EMERGENCY FORM

Date _____ Room _____ Teacher _____

(Return to School Office)

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: _____

Address: *(if different from home above)* _____

Relationship to student _____

Phone: *(home, work, cell)* _____

Contact #2: Name: _____

Address: *(if different from home above)* _____

Relationship to student _____

Phone: *(home, work, cell)* _____

Contact #3: Name: _____

Address: *(if different from home above)* _____

Relationship to student _____

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 _____