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: ____ 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

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.

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Family Physicians: ______________________ Address: ______________________ Phone: __________

____ ____________________

Signature of Parent or Guardian Date