

SIS # _____

**REYNOLDSBURG CITY SCHOOLS
EMERGENCY AUTHORIZATION FORM**
O.R.C.3313.712

**PHOTO
NOT
AVAILABLE**

Student's Name _____

Birthdate _____

Home Address _____

School _____

_____ Zip _____

Teacher _____

Student's Cell Phone (____) _____

Grade _____ Gender M F

Residential Parent/Guardian Information

Student lives with: both parents mother father other _____

Biological parents are: Married Divorced Single-never married Residing together-not married

(Please circle relationship)



please check primary daytime contact number

(Please circle relationship)

Mother / Stepmother / Guardian / Foster Mother

Father / Stepfather / Guardian / Foster Father

Name: _____

Name: _____

Address: _____ Zip _____

Address: _____ Zip _____

Home Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Cell Phone: (____) _____

Employer: _____

Employer: _____

Business Phone: (____) _____

Business Phone: (____) _____

E-Mail: _____

E-Mail: _____

Your mother's maiden name: _____

Your mother's maiden name: _____

Contact person(s) in case parents cannot be reached

This form is utilized if your child becomes ill or has an emergency while at school. It authorizes us to contact additional people should a parent or guardian be unavailable. For this reason, it is important that you list more than one contact number. If your information changes throughout the school year, please be sure to notify the office.

Name: _____

Name: _____

Home Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Cell Phone: (____) _____

Relationship to student: _____

Relationship to student: _____

Major Medical Concerns: _____

My child has NO medical concerns. X _____

Parent signature

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or, in the event that the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the child to 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.

Parent Signature: X _____ Date: _____

TO GIVE CONSENT

You must continue to the back of this page.

Student Name: _____

Medical Alerts

Routine MEDICATIONS: **NO Medications** (including those taken at home)

Name of Medication	Taken For	Activity Restrictions

ALLERGIES: **NO Allergies**

Food: _____

Drug: _____

Insects: _____

Other: _____

EPI-PEN NEEDED

Seasonal/Environmental: _____

Custody

1. Is this child subject to any shared parenting agreement custody order? N/A

Mailing address of other parent if order mandates: _____

2. Is there a court order on file with this school that restricts access to this student by any party? Yes No

If yes, whom: _____ Relation to child: _____

This order cannot be executed until the document has been submitted to Central Registration.

PART II – REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of an emergency or illness requiring treatment, I wish the school authorities to take the following action:

Parent Signature: _____ **Date:** _____

Student's siblings attending Reynoldsburg Schools

Name: _____ Gr.: __ School: ____ Name: _____ Gr.: __ School: ____

Name: _____ Gr.: __ School: ____ Name: _____ Gr.: __ School: ____

Transportation Information

Please mark arrival and dismissal procedures that apply.

Arrival

- Walker Car Rider
- Bus Rider Bus# _____
Bus Stop Location _____
- Daycare / Babysitter
Name _____
Phone # _____

Dismissal

- Walker Car Rider
- Bus Rider Bus# _____
Bus Stop Location _____
- Daycare / Babysitter
Name _____
Phone # _____

CHANGE OF STUDENT ADDRESS

****Transportation changes may require a 1 – 2 day waiting period****

Today's Date _____

residing within RCSD boundaries

Effective Date _____

residing out-of-district – applying to remain under Open Enrollment

*****CHANGES WILL NOT BE MADE WITH TRANSPORTATION UNTIL PROPER VALIDATION IS RECEIVED BY CENTRAL REGISTRATION****

Copies of required documents will be made at the Welcome Center and retained as part of your child's permanent record.

CHANGE OF ADDRESS requires TWO valid proof of new address

1. SIGNED lease (in its entirety) or Purchase Agreement or Notarized Friends/Family Affidavit **PLUS**
2. Utility Bill, insurance statement with current address, some sort of official mail

CHANGE OF CUSTODY requires proof by court order – judge signed and with seal OR agency documentation

Student's Name _____ Grade _____ ID # _____

Gender _____ Date of Birth _____ Building / Academy _____

OLD Street Address _____

Does this move require a change in SCHOOL BUILDING? YES NO APPROVED intra-district
If YES - FROM _____ TO _____ (no bussing)

Has this move resulted from a change in CUSTODY, DIVORCE/SHARED PARENTING? YES NO
(It is required under Ohio Revised Code that ALL custody documents, i.e. divorce, dissolution, shared parenting, court-order, be submitted when the event is effective.)

NEW Street Address _____ APT / Lot # _____

City / ZIP _____ County Franklin Licking Fairfield

How will your student ARRIVE TO school?

BUS PARENT DAYCARE WALK / DRIVE

How will your student LEAVE FROM school?

BUS PARENT DAYCARE WALK / DRIVE

Residential Mother / Stepmother / Guardian NAME _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Residential Father / Stepfather / Guardian NAME _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

PARENT / GUARDIAN SIGNATURE: X _____ **DATE:** _____

OFFICE USE ONLY

Location of Bus Stop: _____ **Bus #** _____ / _____

Pick Up Time _____ **Drop Off Time** _____ **Driver Name** _____

Parent Notified By _____ **Date / Time** _____

KINDERGARTEN/PRE-SCHOOL TRANSPORTATION RELEASE FORMS

SIS#: _____ Student Name: _____ Building: _____

My child will **NOT** be riding a Reynoldsburg City School bus during his/her kindergarten school year.

He/she will be transported by parent/designee or daycare

Name of babysitter or daycare: _____ Phone: _____

Bus Riders

I, the parent or guardian of _____ a Kindergarten/pre-school child, acknowledge that I have read and understand the letter as stated in this packet and the kindergarten/pre-school drop off procedure. I also understand that my child will not be enrolled in the Reynoldsburg Schools until I return this form signed. I further understand that I may contact my school principal to come up with an alternative plan, if there is a hardship, which makes complying with this policy impossible.

X _____
Signature Date

I hereby authorize the driver of Bus # _____ to release my son/daughter, _____, from the school bus for kindergarten/pre-school drop off at the assigned bus stop to the following adult(s) **[must be 18 years of age or older]:**

(PLEASE INCLUDE STUDENT'S PARENTS IF APPLICABLE)

Name & Relationship: _____ Phone: _____

Name & Relationship: _____ Phone: _____

Name & Relationship: _____ Phone: _____

Name & Relationship: _____ Phone: _____

Name & Relationship: _____ Phone: _____

I also agree on behalf of myself and my child, to release, discharge, and hold harmless the Reynoldsburg City Schools and any agent, representative, or employee of such school district from responsibility for any and all harm, which may come to my daughter/son, as a result of this action. I understand it is my responsibility to update this form as changes are needed.

Mother/Guardian: X _____ Date: _____

Father/Guardian: X _____ Date: _____