

SIS # _____

**REYNOLDSBURG CITY SCHOOLS
EMERGENCY AUTHORIZATION FORM**

O.R.C.3313.712



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 # _____