

SIS # _____

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

PHOTO
NOT
AVAILABLE

Student's Name _____ Date of Birth _____

Home Address _____ School _____

_____ Zip _____ Teacher _____

Home Phone (____) _____ Grade _____

Gender: M F

Residential Parent/Guardian Information

Student lives with: both parents mother father other: _____

Mother / Stepmother / Guardian / Foster Mother (please circle relationship)

Name: _____ Daytime Phone: _____

Your Mother's Maiden Name: _____ Work Phone: _____ Ext. _____

Email Address: _____ Cell: (____) _____

Father / Stepfather / Guardian / Foster Father (please circle relationship)

Name: _____ Daytime Phone: _____

Your Mother's Maiden Name: _____ Work Phone: _____ Ext. _____

Email Address: _____ Cell: (____) _____

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.

Contact person(s) in case parents cannot be reached:

Name: _____ Relationship: _____ Phone: _____

Cell: _____

Name: _____ Relationship: _____ Phone: _____

Cell: _____

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 on the next page.

Medical Alerts

NO Medications

Routine MEDICATIONS: _____

Taken for: _____

Activity Restrictions: _____

ALLERGIES: NO Allergies

Food: _____

Drug: _____

Insects: _____

Other: _____

Seasonal/Environmental: _____

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: _____

REFUSAL TO CONSENT

Student's siblings attending Reynoldsburg Schools

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

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

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

TRANSPORTATION INFORMATION: *(if applicable)*

Please mark arrival and dismissal procedures that apply.

Arrival Procedures: (please select one)

Walker Car Rider Bus Rider (Bus# _____) Daycare (_____ Phone# _____)

Bus Stop Location: _____

Dismissal Procedures: (please select one)

Walker Car Rider Bus Rider (Bus# _____) Daycare (_____ Phone# _____)

Bus Stop Location: _____