

**CHANGE OF STUDENT ADDRESS**

**\*Transportation changes may require a 1 – 2 day waiting period if a new bus stop must be created\***

**Today's Date:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

\*\*\* CHANGES WILL **NOT** BE MADE IN THE COMPUTER UNTIL PROPER VALIDATION IS RECEIVED \*\*\*

**CHANGE OF ADDRESS** REQUIRES **TWO** VALID PROOFS OF NEW ADDRESS: PURCHASE AGREEMENT OR LEASE **PLUS** ONE OTHER PROOF – UTILITY BILL, INSURANCE STATEMENT WITH CURRENT ADDRESS, SOME SORT OF OFFICIAL MAIL

**CHANGE OF CUSTODY** REQUIRES PROOF BY COURT ORDER—SIGNED AND WITH SEAL AND/OR SIGNED AGENCY DOCUMENTATION

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ ID#: \_\_\_\_\_

GENDER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ BUILDING: \_\_\_\_\_

**OLD STREET ADDRESS:** \_\_\_\_\_

DOES THIS MOVE REQUIRE A CHANGE IN SCHOOL BUILDINGS? YES NO APPROVED INTRA-DISTRICT

HAS THIS MOVE RESULTED FROM A CHANGE OF CUSTODY? YES NO

**NEW STREET ADDRESS:** \_\_\_\_\_

CITY/ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

**DOES YOUR STUDENT  
REQUIRE  
PICK – UP DROP - OFF**

**RESIDENTIAL** MOTHER/STEPMOTHER/GUARDIAN NAME: \_\_\_\_\_

CELL #: \_\_\_\_\_ WORK #: \_\_\_\_\_

**RESIDENTIAL** FATHER/STEPFATHER/GUARDIAN NAME: \_\_\_\_\_

CELL #: \_\_\_\_\_ WORK #: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** **X** \_\_\_\_\_ DATE: \_\_\_\_\_

***If student will be at a babysitter (must be every day) please complete the lines below!***

CAREGIVER/ NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

EMERGENCY CONTACT HOME #: \_\_\_\_\_ CELL #: \_\_\_\_\_

***A student must have the same pick-up point and drop-off point Monday through Friday.  
The morning pick-up location may be different from the afternoon drop-off points.***

\*\*\*\*\*

**\*\*\* Office Use Only\*\*\***

Location of Bus Stop: \_\_\_\_\_

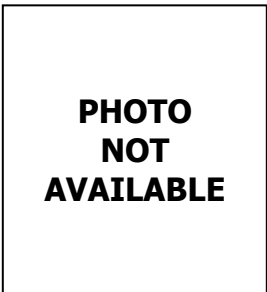
Bus#: \_\_\_\_\_ / \_\_\_\_\_ Pick Up Time: \_\_\_\_\_ / \_\_\_\_\_ Drop Off Time: \_\_\_\_\_ / \_\_\_\_\_

Driver Name: \_\_\_\_\_

Parent Notified By: \_\_\_\_\_ Date/Time: \_\_\_\_\_

SIS # \_\_\_\_\_

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



**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 to the back of this page.***

# Medical Alerts

**NO Medications**

Routine medications: \_\_\_\_\_

Taken for: \_\_\_\_\_

Activity Restrictions: \_\_\_\_\_

**ALLERGIES:**  **NO Allergies**

Food: \_\_\_\_\_

Drug: \_\_\_\_\_

Insects: \_\_\_\_\_

Other: \_\_\_\_\_

Seasonal/Environmental: \_\_\_\_\_

## 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: \_\_\_\_\_