CUYAHOGA FALLS CITY SCHOOLS STUDENT EMERGENCY FORM

School_____

This form **MUST** be completed at the beginning of every school year or if there is a change in address, phone, or parent custody.

STUDENT'S INFORMATION

Name _____
FIRST MIDDLE LAST

Address/City/Zip _____

_____

☐ Check here if address is new

Date of Birth_____

Phone _____ Grade _____

Who has **legal** custody of this student? _____

Student Resides With

☐	Both Parents	☐	Grandmother
☐	Mother	☐	Grandfather
☐	Father	☐	Aunt
☐	Guardian	☐	Uncle
☐	Foster	☐	Aunt
☐	Step-Mother	☐	Sister
☐	Step-Father	☐	Brother

ALERTNOW

The contact numbers will be used to notify you of a building closure and emergency calls for Cuyahoga Falls City Schools.

	Direct Dial Numbers (No Extensions)
Primary Number	( )
Emergency Number	( )
Emergency Number	( )
Emergency Number	( )

Primary Contacts

Relationship to Student_____

First Name _____ Home Phone _____

Last Name _____ Cell Phone _____

Address_____ Work Phone _____

_____ Email_____

Relationship to Student_____

First Name _____ Home Phone _____

Last Name _____ Cell Phone _____

Address_____ Work Phone _____

_____ Email_____

PURPOSE: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority.

Name	Relationship	Phone # 1 ( )	☐ Home	☐ Cell	☐ Work		Phone #2 ( )	☐ Home	☐ Cell	☐ Work
Name	Relationship	Phone # 1 ( )	☐ Home	☐ Cell	☐ Work		Phone #2 ( )	☐ Home	☐ Cell	☐ Work
Name	Relationship	Phone # 1 ( )	☐ Home	☐ Cell	☐ Work		Phone #2 ( )	☐ Home	☐ Cell	☐ Work

PART 1 OR 11 AND PART III MUST BE COMPLETED

Part 1: To Grant Consent I hereby give my consent for the administration of any treatment deemed necessary by the preferred physician, dentist, specialist, and/or hospital listed below: OR in the event the designated preferred practitioner or hospital is not available, by another licensed physician or dentist or 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.

Physician_____ **Phone**_____ ** **Dentist**_____ **Phone**_____ ** **Hospital**_____

Medical Specialist_____Phone_____

Signature of Parent/Legal Guardian_____Date_____

Part II: Refusal to Consent (DO NOT complete if Part 1 above is completed.) I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Signature of Parent/Legal Guardian_____Date_____

SEE REVERSE FOR ADDITIONAL INFORMATION

Part III: Medical History/ Allergies/ Medications Student's Name _____

Medical History _____

Allergies _____ Medications _____

Health Conditions: The following information will be shared with the school nurse, medical assistant, your child's teacher(s) and the administration as necessary to assist in the safety and health of your child during school hours.

Please place a check beside any of the following that your child has had:

_____ Abnormal spinal curvature
_____ Allergies/ hay fever
_____ Anemia
_____ Arthritis
_____ Asthma
_____ Behavior Problems
_____ Birth/ Congenital Malformation
_____ Blood disorder, type _____
_____ Cancer, type _____
_____ Chickenpox
_____ Diabetes
_____ Diarrhea or Constipation (Frequent)
_____ Eczema
_____ Emotional Problems
_____ Headaches (Frequent)
_____ Heart Disease
_____ Hypoglycemia
_____ Kidney Disease
_____ Learning Disability
_____ Lung Disorder, type _____
_____ Meningitis or Encephalitis
_____ Orthopedic Problems
_____ Seizures/ Epilepsy
_____ Sickle Cell Disease
_____ Skin Rashes (Frequent)
_____ Stool Soiling
_____ Throat Infections (Frequent)
_____ Tics/ Nervous Twitches
_____ Urinary Tract Infections
_____ Wetting (Daytime_____, Night _____)

Does your child have a bee/insect or food allergy? Yes_____ No _____

If yes, explain the reaction _____

Does your child require an emergency injection such as an "Epi-pen" for his/her allergic reaction? Yes_____ No_____

Vision & Hearing:
Frequent ear infections? Yes_____ No_____ If yes, which ear? _____ Tubes currently in place? Yes_____ No_____

Reduction in hearing? Yes_____ No _____ If yes, which ear? _____ Last exam? _____

Wears glasses? Yes _____ No_____ Contacts? Yes _____ No _____ Last exam? _____

Medication:
Does your child require medication while at school? Yes _____ No _____

Please remember that if your child requires prescription or over-the-counter medications of any kind during school hours, you will need to request a medication form from the office which will require information and signatures from both a legal guardian and your child's physician. There is a specific law that allows for students to carry inhalers on their person if and only if the proper forms have been completed. For the most part, medications will be dispensed from the clinic. Medications of any type need to be delivered to the school in their original container with directions on the label matching the directions given by the physician on the medication form.

Limitations:
Does your child have any health problems that limit/interfere with school/gym activities? Yes_____ No _____

If yes, please explain _____

_____

Please list any orthopedic, prostheses, or other assistive devices that your child needs during school hours _____

_____

_____ _____

Signature of Parent/Legal Guardian **Date**

8/09