E M E R G E N C Y 1 N F O R M A T 1 O N

STATE LAW REQUIRES THAT THIS FORM BE COMPLETED ANNUALLY AND ON FILE IN THE CLINIC
WILLOUGHBY-EASTLAKE CITY SCHOOLS HEALTH SERVICES

SCHOOL:	STUDENT NUMBER (To be filled in by school):

PLEASE REVIEW INFORMATION ON THE LEFT (below). PRINT ALL NECESSARY CORRECTIONS IN BOXES ON RIGHT.
PLEASE CHECK THE BOX AND SIGN UNDER THE LEFT COLUMN INDICATING THAT NO **CHANGES ARE NEEDED AT THIS TIME** OR **CHECK AND SIGN UNDER THE RIGHT COLUMN IF CHANGES HAVE BEEN REQUESTED.**

STUDENT DEMOGRAPHIC INFORMATION	
	C O R R E C T I O N S O N L Y
Name:	Name:
Address:	Street: Apt:
	City: Zip:
Home Phone:	Home Phone:
Birth Date: Grade:	Birth Date:

PARENT or LEGAL GUARDIAN	***Check Here If This Is GUARDIAN Information:*** ☐
For Office Use – Contact ID	**C O R R E C T I O N S O N L Y**
Name:	Name:
Address:	Street: Apt:
	City: Zip:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Pager Number:	Pager Number:
Email Address:	Email Address:

FATHER'S WORK INFORMATION	
For Office Use – Contact ID	**C O R R E C T I O N S O N L Y**
Name:	Name:
Company:	Company:
Daytime Phone:	Daytime Phone:
Cell Phone:	Cell Phone:
Pager Number:	Pager Number:

MOTHER'S WORK INFORMATION	
For Office Use – Contact ID	**C O R R E C T I O N S O N L Y**
Name:	Name:
Company:	Company:
Daytime Phone:	Daytime Phone:
Cell Phone:	Cell Phone:
Pager Number:	Pager Number:

EMERGENCY CONTACT INFORMATION	
For Office Use – Contact ID	**C O R R E C T I O N S O N L Y**
Name:	Name:
Daytime Phone:	Daytime Phone:
Cell Phone:	Cell Phone:
Pager Number:	Pager Number:
Relationship:	Relationship to student:

ALTERNATE EMERGENCY CONTACT INFORMATION	
For Office Use – Contact ID	**C O R R E C T I O N S O N L Y**
Name:	Name:
Daytime Phone:	Phone:
Cell Phone:	Cell Phone:
Pager Number:	Pager Number:
Relationship:	Relationship to student:

☐ **I have verified information on the left. All data is accurate. NO changes are needed at this time.**

☐ **I have reviewed the data above and have made changes as necessary in the boxed areas on the right side of this form.**

PARENT/GUARDIAN SIGNATURE _____

IMPORTANT- OVER – SEE BACK

Medical Authorization

Section 3313.712, Ohio Revised Code (Pursuant AM.H.B.1175)

Instructions: **Part I MUST** be completed ***AND*** Complete either PART II **OR** PART III

Part I: MUST BE COMPLETED

In an emergency, when it is impossible to contact you, do you authorize the school to take your child to the nearest hospital? ☐ Yes ☐ No

Does your child have Health insurance? ☐ Yes ☐ No

If Yes, who is the carrier? _____

Part II: To GRANT CONSENT

IMPORTANT

The following facts concerning my child's medical history including allergies, medications being taken, and any physical impairments to which a physician and appropriate school personnel should be alerted and updated annually are:

_____

_____

_____

I hereby give consent for the following medical care providers and a/the local hospital to be called:

Doctor: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

Medical Specialist: _____ Phone Number: _____

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 above-named doctor, or, in the event designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to Lake West 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.

Date: _____ Signature of Parent/Guardian _____

PART III: REFUSAL TO CONSENT (Do NOT complete if you completed PART II)

I do not give 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 no action or to: _____

_____

Date: _____ Signature of Parent/Guardian _____