# Willoughby-Eastlake Schools Health Services Student Emergency Information

*STATE LAW REQUIRES THAT THIS FORM BE COMPLETED ANNUALLY AND ON FILE IN THE CLINIC*

**Student Name:** _____ **ID:** _____

**Homeroom:** _____ **GR:** _____

**Custody of Student:** ◯ Both Parents ◯ Mother Only ◯ Father Only ◯ Shared Parenting ◯ Grandparent* ◯ Father/Step-Mother ◯ Mother/Step-Father ◯ Partner/Partner ◯ Guardian/Foster/Host ◯ Self

**Please review information on left (below). Print all necessary corrections in the boxes on right.**

| | Current Information | Corrections Only |
|---|---|---|
| Email Address | | |

| | Current Information | Corrections Only |
|---|---|---|
| Date of Birth | | |
| Home Phone | | |
| **Home Address** | | |
| Street | | |
| City, Zip | | |
| **Mailing Address** | | |
| Street | | |
| City, Zip | | |

| | ☐ Father | ☐ Step Father | ☐ Legal Guardian |
|---|---|---|---|
| Father Name | | | |
| Father's Day Phone | | | |
| Father's Employer | | | |
| Father's Cell Phone | | | |
| Fathers Street, City, Zip *(If different from above)* | | | |

| | ☐ Mother | ☐ Step Mother | ☐ Legal Guardian |
|---|---|---|---|
| Mother Name | | | |
| Mother's Day Phone | | | |
| Mother's Employer | | | |
| Mother's Cell Phone | | | |
| Mother's Street, City, Zip *(If different from above)* | | | |

| Emergency Contact - Other Than Parent | | |
|---|---|---|
| Contact Name | | |
| Relationship | | |
| Phone | | |

| Alternate Emergency Contact | | |
|---|---|---|
| Contact Name | | |
| Relationship | | |
| Phone | | |

☐ **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.**

Please turn over and complete information on 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**

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.

**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:**

_____

_____

_____

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 _____