Immaculate Conception Catholic School

Emergency Medical Form Todays Date:_____

Student Information

Last Name:_____ First Name:_____ Date of birth:_____ O Male O Female

Home Address:_____ City:_____

Primary Home Phone Number:_____ Student's Cell Phone Number:_____

Contact/Residency Information

If there is a custody order allocating parental rights and responsibilities, or if the student is placed with a legal guardian, legal documents which declare placement must be provided to the school. Please include a certified copy of the court order and any future changes in custody.

MOTHER'S INFORMATION

Residential/Parent/Legal Guardian ☐ **YES** ☐ **NO**

Name:_____

Address_____

***Mailing* address if different from above:**

_____

Daytime Phone Number_____

Home Phone Number _____

Mobile Phone Number_____

Employer:_____

Work Phone Number:_____

Do you wish to receive school correspondence via email? (if yes):

Email Address:_____

FATHER'S INFORMATION

Residential/Parent/Legal Guardian ☐ **YES** ☐ **NO**

Name:_____

Address_____

***Mailing* address if different from above:**

_____

Daytime Phone Number_____

Home Phone Number _____

Mobile Phone Number_____

Employer:_____

Work Phone Number:_____

Do you wish to receive school correspondence via email? (if yes):

Email Address:_____

LEGAL GUARDIAN INFORMATION
OTHER THAN PARENTS
Does not apply (check here) ☐

Name:_____

Address_____

***Mailing* address if different from above:**

_____

Daytime Phone Number_____

Home Phone Number _____

Mobile Phone Number_____

Employer:_____

Work Phone Number:_____

Do you wish to receive school correspondence via email? (if yes):

Email Address:_____

EMERGENCY CONTACTS

Please list 3 people (locally) we may call in the event of an emergency if the parent/guardian cannot be reached. These emergency contacts also have your permission to pick up your child during the school day. List in order of priority.

1. Name: _____

Relationship to student:_____

Telephone Number:_____

2. Name: _____

Relationship to student:_____

Telephone Number:_____

3. Name: _____

Relationship to student:_____

Telephone Number:_____

Student's Name:_____

List all health concerns and problems:

_____

_____

List all allergies and any special precautions or treatments for these allergies:

_____

_____

List all medications currently being administered to the child:

_____

_____

Please list siblings and school attending:

_____

Section 3313.712 ORC (A) Annually the board of education of each city, exempted village, local, and joint vocational school district shall, before the first day of October, provide to the parent of every pupil enrolled in schools under the board's jurisdiction, an emergency medical authorization form that is an identical copy of the form contained in division (B) of this section. Thereafter, the board shall, within thirty days after the entry of any pupil into a public school in this state for the first time, provide his parent, either as part of any registration form which is in use in the district, or as a separate form, an identical copy of the form contained in division (B) of this section. When the form is returned to the school with Part I or Part II completed, the school shall keep the form on file, and shall send the form to any school of a city, exempted village, local, or joint vocational school district to which the pupil is transferred. Upon request of his parent, authorities of the school in which the pupil is enrolled may permit the parent to make changes in a previously filed form, or to file a new form.

Part I or Part II must be completed. DO NOT COMPLETE BOTH PARTS

PART I TO GRANT CONSENT

Doctor:_____ Phone: _____ O No preference

Dentist:_____ Phone: _____ O No preference

Hospital:_____ Phone: _____ O No preference

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 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 opinion of two other licensed physicians or dentists concurring in the necessity for such surgery, are obtained prior to the performance of surgery.

In radiological emergency Potassium Iodide (KI) may be given to my child if recommended by the Ohio Department of Health

O Yes O No

By signing this, I also give my permission to the school personnel to share my child's health/medical concerns (past/present) with school personnel on an "as needed to know" basis, unless I notify the school administration in writing that I do not want it shared.

Signature of Parent: _____ Date: _____

_____

PART II: REFUSAL OF CONSENT: DO NOT COMPLETE IF YOU HAVE COMPLETED PART I

I do NOT give my consent for emergency medical treatment for my child. In the event of illness and injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Signature of Parent or Guardian:_____ Date:_____