

OTTAWA-GLANDORF SCHOOLS

Student Name _____

Date of Birth _____

Home Address _____

Please check if this is a new address from previous school year.

Home Phone _____

Please check if this is a new number from previous school year.

E-Mail Address _____

Grade Level/Homeroom _____ School Year _____

EMERGENCY MEDICAL AUTHORIZATION FORM 5341

Rev 11-2017

Custodial Parent(s) _____

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. **Please number** in order of who should be called first, second and third.

| | | | Home | Work | Cell | |
|-------|---------------|------------|---------------|--------------------------|--------------------------|--------------------------|
| _____ | Mother's Name | Work Place | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | Father's Name | Work Place | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | Other's Name | Work Place | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Name of relative or childcare provider to be contacted in the event parents cannot be reached: (please list at least two)

| | | | Home | Work | Cell | |
|-------|------|--------------|---------------|--------------------------|--------------------------|--------------------------|
| _____ | Name | Relationship | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | Name | Relationship | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | Name | Relationship | Daytime Phone | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If this is a divorced and separated home, list below the Court Docket Number which gives the name of the person(s) having legal custody: (must have a copy on file)

Docket Number _____ State of _____ Copy on File: Yes _____ No _____

Date of Docket _____ Person(s) having legal custody _____

If not living with person of legal custody, state name of person with whom child is living:

Name _____ Relationship _____

Address _____

FIELD TRIP PERMIT

My student has permission to go with a school chaperoned group on field trips away from the building.

Signature of Parent/Guardian _____ Date _____

PUBLICITY PERMIT/CLASS ROSTER

Ottawa-Glandorf Schools have permission to use my child's name and photograph in any school-related news release to local and area newspapers and to make available, upon request, student directory information. Permission is also granted for school-related photographs/videos of my child to be posted on the school's website and/or viewed on school's closed-circuit television. (Full name will not be used.)

Signature of Parent/Guardian _____ Date _____

CONTACT INFORMATION

LEGAL CUSTODY

PERMISSION

PART I OR II MUST BE COMPLETED

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

| | |
|---|-------------------------------|
| _____ Doctor | _____ Phone |
| _____ Dentist | _____ Phone |
| _____ Optometrist | _____ Phone |
| _____ Medical Specialist (if needed) | _____ Phone |
| _____ Local Hospital | _____ Emergency Room 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 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 opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which the schools should be alerted:

Allergies (bee stings, foods, etc.) _____

Medications Taken _____

Physical Impairments _____

Asthma _____

Seizures _____

Diabetes _____

Names of other children in your family:

Signature of Parent/Guardian _____ *Date* _____

REFUSAL TO CONSENT

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 no action; or to: _____

Signature of Parent/Guardian _____ *Date* _____

ATHLETIC INSURANCE

- ___ My child does **not** plan to participate in any athletic program sponsored by Ottawa-Glandorf Schools.
- ___ My child plans to participate in athletics sponsored by Ottawa-Glandorf Schools and has permission to participate in the following sport(s): _____

We understand that our child must be covered by insurance to participate. In the event of an injury, we will cover the medical expenses. We understand that the school does not carry any insurance on student athletes.

We also give permission for the school person in charge to determine when our child should be taken for emergency medical treatment. We have instructed our student athlete to report all injuries to the person in charge immediately.

Signature of Parent/Guardian _____ *Date* _____

MILITARY STUDENT IDENTIFIER

- ___ My child is a dependent of a member of the active duty forces. (*Army, Navy, Air Force, Marines Corp or Coast Guard*)
- ___ My child is a dependent of a member of the National Guard. (*Army or Air*)

Signature of Parent/Guardian _____ *Date* _____

PART I

PART II

INSURANCE

MILITARY

OR