

**NORDONIA HILLS CITY SCHOOL DISTRICT**

**STUDENT CONTACT/EMA FORM**

PLEASE CONTACT THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES

Student's Last Name \_\_\_\_\_ Student's First Name \_\_\_\_\_ Gender \_\_\_\_\_

Student resides with  Both Parents  Mother  Father  Guardian  Foster \_\_\_\_\_ Date of Birth \_\_\_\_\_

Are current custody papers on file with the school (CHECK ONE) Yes \_\_\_\_\_ No \_\_\_\_\_

CUSTODY ALERTS (court ordered) \_\_\_\_\_

Shared Parenting

**Mother/Guardian's First/Last Name** \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_

**Father/Guardian's First/Last Name** \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Email Address \_\_\_\_\_

Employer \_\_\_\_\_

**Phone Contact Information**

Only the Primary contact numbers listed below will be used for Special Announcements and Emergency Calls through the phone contact calling system. (Please list only one number)

Primary # (All calls) \_\_\_\_\_

Relationship \_\_\_\_\_

**OTHER CONTACTS** The following names will only be called when the student's mother/father/guardian cannot be reached. They are authorized to pick up your student due to emergency situations such as illness, school evacuation, or any other type of dismissal.

**Other Contacts**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Mother/Father/Guardian (Approving information listed above)

Date \_\_\_\_\_

PLEASE CONTACT THE SCHOOL IMMEDIATELY IF ANY INFORMATION CHANGES

**EMERGENCY MEDICAL AUTHORIZATION**

Purpose: To enable mother/father/guardian to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when mother/father/guardian cannot be reached.

**\*\*YOU MUST CHOOSE BETWEEN FILLING OUT PART 1 OR PART 2\*\***

**PART 1 (TO GRANT CONSENT)**

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

DOCTOR/PHONE \_\_\_\_\_ LOCAL HOSPITAL/EMERGENCY/PHONE \_\_\_\_\_

DENTIST/PHONE \_\_\_\_\_ MEDICAL SPECIALIST/PHONE \_\_\_\_\_

In the event that 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 licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including medical concerns and/or allergies to which physicians should be alerted: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Mother/Father/Guardian (Approving Information listed above)

Date \_\_\_\_\_

**PART 2 (REFUSAL TO CONSENT) \*\*\*DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1**

I do NOT give my consent for emergency treatment of my child in the event of illness requiring emergency treatment. I wish the school authorities to take NO action or to \_\_\_\_\_

Signature of Mother/Father/Guardian (Approving Information listed above)

Date \_\_\_\_\_