

Crestview Local Schools
Emergency Information and Authorization

(Form available at www.crestviewknights.com)

Information must be completed each school year and returned to the office.

Student's legal name _____ **Date of Birth** _____ **Grade** _____

Prefers to be called _____ Bus Number _____

List all Crestview students that live with student _____

STUDENT'S PRIMARY RESIDENCE (CUSTODIAL PARENT)

Father's name _____

Mother's name _____

Stepparent's name _____
(if applicable)

Street address _____

PO Box _____

City _____ Zip _____

Home Phone _____

MOTHER'S CONTACTS (or stepmother if applicable)

Cell phone _____

Work phone _____

E-mail _____

FATHER'S CONTACTS (or stepfather if applicable)

Cell phone _____

Work phone _____

E-mail _____

NON-CUSTODIAL PARENT INFORMATION

Name _____

Stepparent's name _____

Street address _____

PO Box _____

City _____ Zip _____

Home Phone _____

PARENT'S CONTACTS

Cell phone _____

Work phone _____

E-mail _____

STEPPARENT'S CONTACTS

Cell phone _____

Work phone _____

E-mail _____

Mark "X" if applies Legal guardian Send school reports

Parenting schedule Weekends only Every other week

No contact Other _____

In case of minor illness or injury please attempt to contact the following persons in order. The student may be released to those named. Complete at least 3. **INCLUDE PARENTS IN THIS LIST**

1. Name _____ Phone(s) _____ Relation _____
2. Name _____ Phone(s) _____ Relation _____
3. Name _____ Phone(s) _____ Relation _____
4. Name _____ Phone(s) _____ Relation _____
5. Name _____ Phone(s) _____ Relation _____

Both sides of this form must be completed in blue or black ink and signed

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Mark "X" if your child has the following diseases or conditions:

- Asthma
- Diabetes
- Epilepsy/ Seizures
- ADD/ADHD
- Frequent nosebleeds
- Frequent ear infections
- Frequent urinary tract infections

- Seasonal allergies
- Food allergies – please name _____
- Bee sting allergy
- Latex allergy
- Medication allergy –please name _____
- Other allergy – please name _____

Other health conditions - please name or describe _____

Wears glasses Wears contacts Wears hearing aides Uses other assistive devices - name _____

List any medications and dosages currently being taken _____

List any additional information regarding physical or mental health of which the school nurse, teacher or bus driver should be aware _____

The school nurse may use triple antibiotic ointment, Caladryl, Bactine, cough drops and aloe gel for this student as written in the standing orders (see student handbook). yes no _____

Mark "X" on one of the following and complete:

GRANT CONSENT FOR EMERGENCY TREATMENT

In the event that reasonable attempts to contact parents have been unsuccessful, I hereby consent for:

1) the administration of any treatment deemed by Dr. _____ (preferred physician) phone# _____
or Dr. _____ (preferred dentist) phone # _____, or in the event designated practitioner is not available, by another licensed physician or dentist; 2) the transfer of the child to _____ (preferred hospital) or any other hospital reasonably accessible. This authorization does not cover major surgery unless medical opinion of two other licensed physicians or dentists concur in the necessity of such surgery.

REFUSAL TO CONSENT FOR EMERGENCY TREATMENT

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 authorities to take no action or to _____

The information provided is complete and accurate. I understand that this information will be given to my child's teacher(s), bus driver(s) and the school nurse. This information will be provided to Emergency Medical Services if needed. The original form will be kept in the school office. If further information is required or changes occur, I will contact the school.

Parent/Guardian Signature _____ **Date** _____

Both sides of this form must be completed in blue or black ink and signed