MADISON LOCAL SCHOOLS

EMERGENCY MEDICAL FORM - School Year 2020-2021

Student Information: ***Please keep school advised of address and phone number changes.***

Student Name: _____Date of Birth: _____ Grade: _____
Address: _____ Phone: _____

Facts about your child's medical history to which the school and/or a physician should be alerted: (example: medical conditions, physical impairments, food allergies, other allergies, medications (including purpose and dosage), and any other pertinent information:

* * * CONTACT INFORMATION * * *

Only those listed on this form are authorized to pick up this student. Student will not be released to anyone not showing photo identification. *If needed, additional contact information may be added on the* ***back of this page****.*

PARENT / GUARDIAN INFORMATION

Please indicate custodial parent. Circle the option that applies: MOTHER FATHER BOTH OTHER

Parent/Guardian Child Lives With:

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____
Email: _____
Place of Employment: _____
Work#: _____

Name: _____
Relationship: _____
Address: _____
Cell# _____ Home# _____
Email: _____
Place of Employment: _____
Work#: _____

Alternate Contacts

Name: _____
Relationship: _____
Cell# _____ Home# _____

Name: _____
Relationship: _____
Cell# _____ Home# _____

Medical Consent: The following physicians have consent to treat your child in case of emergency:

Doctor: _____ Phone Number: _____
Dentist: _____ Phone Number: _____
Medical Specialist: _____ Phone Number: _____
Preferred Hospital: _____ Phone Number: _____

Consent/Refusal - This must be completed – Please check one of the following & sign below:

☐ In the event reasonable attempts to contact me have been unsuccessful, **I HEREBY GIVE CONSENT** for the (1) administration of any treatment deemed necessary by the above named physicians for dentist, and (2) the transfer of child to any hospital reasonably accessible.
Note: 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.

☐ **I DO NOT GIVE CONSENT** for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I request that the school authorities take the following action: _____
_____

Parent/Guardian Signature: _____ Date: _____

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Madison Local Schools

STUDENT HANDBOOK CERTIFICATION

We, _____ and _____
Parent/Guardian Student

have received and read the _____. We understand the rights and responsibilities pertaining to students and agree to support and abide by the rules, guidelines, procedures, and policies of the School District.

_____
Parent/Guardian Signature

_____
Student Signature

_____
Date

Military Student Identifier Collection Form

As required by the Ohio Department of Education and the Every Student Succeeds Act, school districts are required to collect and report dependents who are in an active military family.

Parent or legal guardian of student is: (check what applies)

____* Not Applicable. Not a Military Student.

____A) Active Duty. Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard).

____B) National Guard. Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard).

____C) Reserves.