CARLISLE LOCAL SCHOOL EMERGENCY MEDICAL FORM

Student's Name_____ Date of Birth_____ Grade Level_____ Homeroom_____

This form is used exclusively for emergency transport information only. No information is updated from this form.

Who has custody of this child? Please check: _____ Parents _____ Mother _____Father _____ Other

FATHER/GUARDIAN:

Name _____

Address _____

City/State/Zip _____

Home Phone _____Cell_____

Place of Employment _____

Are you in the Military? Yes No Branch:_____

Active Duty? Yes No Other (please list):_____

Work Phone _____

STEPMOTHER (if applicable) _____

Work phone _____ Cell_____

MOTHER/GUARDIAN:

Name _____

Address_____

City/State/Zip _____

Home Phone _____Cell_____

Place of Employment _____

Are you in the Military? Yes No Branch:_____

Active Duty? Yes No Other (please list):_____

Work Phone _____

STEPFATHER (if applicable) _____

Work phone _____ Cell_____

I, the undersigned, do hereby state and declare under penalty of falsification (*) that I am the parent or legal guardian of the student named on this form and that this information is true and correct.

Parent/Guardian Signature _____ **Date** _____**Family Email:**_____

(*) Falsification under Ohio Revised Code section 2921.13 is a misdemeanor of the first degree punishable by a maximum of six months imprisonment or a fine of $1,000 or both.

****District procedure is Primary Contact will be contacted first.**
For New Students: Primary contacts information will be entered from the Family Groups Form (In Registration Packet)
For Returning Students: To have primary contact information updated, please contact your child's school building..

Please check if your child has any of the following:

____ADD/ADHD ____Asthma ____Anxiety Disorder ____Cancer ____Cerebral Palsy ____Cystic Fibrosis ____Dental Problems ____Diabetes

____Digestive Disorder ____Ear Problems ____Eye Problems ____Heart Disease ____Headaches/Migraines ____Seizures ____Urinary Problems

Please check if your child wears: glasses_____ hearing aids_____ braces_____ artificial limb_____ other:_____

Were there problems during your pregnancy or delivery of this child? If so, Please describe:_____

Has your child ever been hospitalized: Yes: _____ No: _____ If yes, briefly describe:_____

Is your child taking any medication(s) prescribed by a doctor? Yes:_____ No: _____

If yes, what kind of medication?_____ What is it for?_____

Does your child have any allergies? Yes:_____ No:_____ If yes, to what?_____

What effects does this allergy have that we need to know about?_____

Has your child had: CHICKEN POX? Yes:_____ No:_____

HIGH FEVERS: Yes:____ No:____ If yes, how high? _____ Cause:_____, any effect of which you know?_____

EMERGENCY MEDICAL AUTHORIZATION (REQUIRED PER HB 639)

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority.

PART I – TO GRANT CONSENT

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

Doctor _____ Phone ( ) _____

Dentist _____ Phone ( ) _____

Hospital _____ 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 practitioner is unavailable, 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 to the performance of such surgery.

Date_____ Signature of Parent/Guardian _____

PART II – REFUSAL TO GRANT CONSENT

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

Date_____ Signature of Parent/Guardian _____