SHEFFIELD-SHEFFIELD LAKE CITY SCHOOLS
Emergency Medical Form

School Use Only

Name: Last	**First**	**MI**	**DOB: (mm/dd/yyyy)**
Address:	**City:**	**State: OH**	**Zip:**
Home Phone:		**Cell Phone:**	
School:	**Grade:**	**Teacher:**	**Homeroom:**
List Siblings & School They Attend			
Please List Any Medical Issues or Allergies:		**Does the Student Wear Contacts or Glasses?** **Yes** **No**	

PARENT/GUARDIAN INFORMATION

PRIMARY ADULT IN HOUSEHOLD		**SECONDARY ADULT IN HOUSEHOLD**	
Name:	**Relationship to Student**	**Name:**	**Relationship to Student**
Address (if different):		**Address (if different):**	
Day Phone:	**Evening Phone:**	**Day Phone:**	**Evening Phone:**
Email:		**Email:**	
Employer Name & Phone No.		**Employer Name & Phone No.**	
Daycare/Babysitter Name: (if applicable)		**Phone No:**	

CUSTODIAL INFORMATION

Legal Custodian of Student (Please check appropriate box)

Mother ☐ Father ☐ Shared ☐ Guardian ☐ Other ☐ *Name & Relationship _____

EMERGENCY CONTACT INFORMATION

In the case of an emergency, I authorize the school to release my child to one of the following individuals listed below.
*__*The child will not be released to anyone not listed.*__

Name & Phone (Local Contact)	**Name & Phone** (Local Contact)
Name & Phone (Local Contact)	**Name & Phone** (Local Contact)

EMERGENCY MEDICAL AUTHORIZATION

I do hereby give my consent, in the event that all reasonable attempts to contact me at the above phone numbers, or contact with other individuals listed above have been unsuccessful, for the administration of any treatment deemed necessary by:

Preferred Hospital:	**Preferred Doctor:** **Phone No.:**	**Preferred Dentist:** **Phone No.:**

☐ I refuse to consent to any emergency treatment of my child. In the event of illness/injury requiring emergency treatment, I want the school officials to do the following: _____

☐ I grant permission for my child's picture to be published on the school webpage, Cardinal TV, newspaper/newsletter.

Parent Signature & Date: _____