Hilliard City School District

Emergency Information Form

Last Name: _____ First Name: _____ Middle Name: _____

Student ID: _____ Grade: _____ SSN: _____

Address: _____ Phone Number: _____ Birthdate: _____

City/State/Zip: _____ Listed/Unlisted: _____ Homeroom: _____

Childcare Provider: _____ Childcare Provider Phone: _____

People to call when student is ill, or in case of emergency:

Relationship	*Name*	*Work Phone*	*EXT*	*Employer*	*Cell Phone/Pager*
Mother					
Father					
Step Mother					
Step Father					
Other 1					

Relationship: **(Relative, Guardian, etc...)**

Other 2				

Relationship: **(Relative, Guardian, etc...)**

Child Lives with:

___Mother/Father ___Mother Only ___Father Only ___Guardian ___Mother/Stepfather ___Father/Stepmother ___Grandparents ___Foster Parents ___Self Supporting ___Other

Guardianship:

___Mother/Father ___ Mother Only ___ Father Only ___ Guardian ___ Grandparents ___ Foster Parents ___Self Supporting ___ Shared Parenting ___ Other

Custody Papers on file (IF APPLICABLE): _____

Non Custodial Parent/Shared Parent Address

Guardian Name	Street	City State Zip

Emergency Medical Authorization

PURPOSE: To enable parents to authorize emergency medical treatment for children who become ill or injured while under school authority, when parents cannot be reached.

********** You MUST complete PART I or PART II **********

Part I (To grant consent)

In the event that reasonable attempts to contact me or the other parent have been unsuccessful, I hereby give my consent (1) for the administration of any treatment deemed necessary by our physician or dentist, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) for the transfer of the child to our preferred hospital or one that is reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Preferred Doctor: _____ Preferred Dentist: _____

Preferred Hospital: _____

Allergies and Medical Conditions: _____

_____

Parent Signature: _____

********** PART II (Refusal to consent to treatment) **********

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

I DO NOT give my consent for emergency medical treatment of the child in the event of illness or injury requiring treatment. I wish the school authorities to take no action, or to: _____

_____

_____

Parent Signature: _____