Jackson-Milton Local Schools

RETURN THIS FORM IMMEDIATELY
Students risk exclusion for failure to return this form

Date: _____ Grade: _____

Teacher: _____

Name

Student Name: _____ Male ____ Female ____

Address: _____ City _____ Zip: _____

Home Phone: _____ Date of Birth: _____ Age: _____ SS# _____

Parent/Guardian & Relationship

☐ **Please check** if any change in address and/or custody
(Must provide documentation)

Name: _____ Name: _____

Address: _____ Address: _____

City, Zip _____ City, Zip: _____

Work Phone #'s: _____ Work Phone #'s: _____

Other Phone #'s_____ Other Phone #'s_____

Email Address: _____ Email Address: _____

Relationship to Student: _____ Relationship to Student: _____

Daycare/Other: _____ Phone: _____

Siblings' Name & Date of Birth: 1. _____ 3. _____

2. _____ 4. _____

If Parents Are Separated Or Divorced Who Has Custody? (Court documentation must be on file at school)

Custodial Parent/Guardian: _____

Address: _____ Phone: _____

If Parents Are Not Available, In Case Of Emergency Call:
(The individual listed will be permitted to sign this student out of school when parent can't be contacted)

1. Name: _____ 3. Name: _____
   Phone: _____ Phone: _____
   Relationship to Student: _____ Relationship to Student: _____
2. Name: _____ 4. Name: _____
   Phone: _____ Phone: _____
   Relationship to Student: _____ Relationship to Student: _____

In Case Of Emergency Dismissal, My Child Should Go To This Local Address:

_____

(OVER) SIDE 2 MUST BE COMPLETED

Please describe medical conditions your child has including instructions for school or hospital staff to follow in the event of an emergency: (please note that every effort possible will be made to contact individuals listed on this form first; however realize that it may not always be possible to reach those listed! Give information accordingly. Please list such things as allergies and medical conditions, etc.) This information will be provided to hospital staff (if necessary) or school staff unless instructed otherwise.

_____

_____

_____

_____

Dentist: _____ Phone: _____

Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Permission to contact child's doctor if necessary: Yes _____ No _____

Health Insurance: _____ Policy # _____ Group # _____

Insured Name: _____

Preferred Hospital: _____

Medications: _____ _____

_____ _____

_____ _____

PLEASE SIGN ONLY ONE LINE BELOW INDICATING YOUR WISHES:

Part I – To Grant Consent:

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named doctor, or, in the event the designated preferred practitioner is not available, 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's history including allergies, medications being taken, and any physical impairments to which a physician should be alerted are listed above.

_____ _____

Signature of Parent/Guardian Date

Part II – Refusal to Consent:

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 school authorities to take the following action:

_____

_____

_____ _____

Signature of Parent/Guardian Date