

Gallia County Local Schools

NEW STUDENT BUS BOARDING PASS

School Attending_____

Student Name_____

DOB ___ / ___ / ___ Age ___ Grade ___

Address_____ City_____ State_____ Zip_____

Guardian Name_____

Phone_____ Emergency Phone_____

Driver Name Bus# AM Pickup Time PM Drop Off Time

APPROVAL STAMP

EMERGENCY MEDICAL STUDENT AUTHORIZATION FORM

SCHOOL _____ DATE _____ GRADE _____

STUDENT NAME _____

HOME ADDRESS _____

BOX _____ STREET/ROAD _____ CITY _____ ST _____ ZIP _____

MAILING ADDRESS (if different) _____

Is student open enrollment? Yes No Resident District _____

AGE _____ BIRTH DATE _____ GENDER M F

STUDENT LIVES WITH Both Parents Mother Only Father Only Grandparents Other

GUARDIAN'S NAME _____ GUARDIAN'S NAME _____

ADDRESS IF DIFFERENT _____ ADDRESS IF DIFFERENT _____

HOME PHONE _____ HOME PHONE _____

CELL PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____ EMAIL ADDRESS _____

WORK PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____ PLACE OF EMPLOYMENT _____

STEP-FATHER (IF APPLICABLE) _____ STEP-MOTHER (IF APPLICABLE) _____

CELL PHONE _____ CELL PHONE _____

MOTHERS MAIDEN NAME _____

IF SOMEONE OTHER THAN MOTHER/FATHER HAVE CUSTODY

NAME _____

PHONE NUMBER _____ CELL PHONE _____

EMAIL ADDRESS _____

PLEASE LIST ALL STUDENTS RESIDING THE HOME (who are under the age of 19 or enrolled in a building/school in our district):

LAST _____ FIRST _____ GRADE _____ AGE _____

NAME _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

PLEASE LIST IN ORDER, PEOPLE TO BE CONTACTED in event child needs to be released to other than care giver (Parents will be contacted first inless stated otherwise)

NAME _____ HOME PHONE _____ CELL PHONE _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

NAME _____ HOME PHONE _____ CELL PHONE _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

NAME _____ HOME PHONE _____ CELL PHONE _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

NAME _____ HOME PHONE _____ CELL PHONE _____

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RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

NAME _____ HOME PHONE _____ CELL PHONE _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

NAME _____ HOME PHONE _____ CELL PHONE _____

RELATIONSHIP _____ HOME PHONE _____ CELL PHONE _____

MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALERTED (ALLERGIES, PHYSICAL IMPAIRMENT, MEDICATIONS BEING TAKEN ETC.)

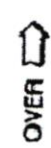
In the event reasonable attempts to contact me have been unsuccessful I hereby give my consent for (1) the administration of any treatment deemed necessary by any licensed physician or dentist and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 other license physicians or dentist, concurring in the necessity of such surgery are obtained prior to the performance of surgery. I understand medical information may be shared with appropriate school personnel as deemed necessary by the school administration.

Physicians Name _____ phone# _____

Dentist Name _____ phone# _____

Date _____ Signature of Parent/Guardian _____

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

OVER 

Gallia County Local Schools District
Confidential History Form

TODAY'S DATE _____ SCHOOL ENROLLING TODAY _____

STUDENT'S NAME: LAST _____ FIRST _____ MIDDLE _____

CURRENT GRADE: _____ DATE OF BIRTH ____/____/____ GENDER: M F

MOTHER'S NAME _____ PHONE: _____

FATHER'S NAME _____ PHONE: _____

CHILD LIVES WITH: MOTHER FATHER GRANDPARENT GUARDIAN OTHER _____

CHILD'S PRIMARY ADDRESS: _____

SIBLINGS AND AGES: _____

DOES YOUR CHILD HAVE: IEP YES NO 504 PLAN Y N SPECIAL EQUIPMENT Y N

DOES YOUR CHILD HAVE ALLERGIES (FOOD, MEDICATIONS, INSECTS, LATEX, ETC)? Y N

IF YES, PLEASE LIST ALLERGY AND TREATMENT _____

Please list any medications/treatments this student requires daily (even if not needed at school): _____

CHECK ANY OF THE FOLLOWING THAT APPLY TO THIS STUDENT:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> No Health Conditions | <input type="checkbox"/> Vision Impairments | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> MusculoSkeletal Issues |
| <input type="checkbox"/> ADHD/ADD | <input type="checkbox"/> amblyopia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> wears glasses/contacts | <input type="checkbox"/> Menstrual Issues | <input type="checkbox"/> Mental Health Concerns |
| <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> color vision deficits | | <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cardiac Issues | <input type="checkbox"/> Kidney Issues | <input type="checkbox"/> Hearing Issues |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vascular Issues | <input type="checkbox"/> Liver Issues |
| | | | <input type="checkbox"/> Hearing Aides R/L |

If you checked any of the above boxes, please describe the condition and current treatments:

If this student has had accidents or surgery, please list the dates and nature of each:

Please list any concerns not already listed that the school nurse/teacher need to address: