



Greenon Local Schools
 500 Enon-Xenia Rd.
 Enon, Ohio 45323
 937-864-1202

OFFICE USE ONLY	
Student ID:	
HR:	
Other:	

EMERGENCY MEDICAL FORM

2026-2027 SCHOOL YEAR

To be completed by the parent or legal guardian (or the student if age 18 or older).

I. GENERAL STUDENT INFORMATION

<u>Student's Legal Name</u> (as it appears on Birth Certificate)				
First Name	Middle Name	Last Name	Called Name	
Address			City	Zip Code
Home Phone	Gender	Date of Birth	Automated Notification Phone # (One Call Now)	2026-2027 Grade
	M _____ F _____		See page 2 for details	
Is your child permitted to participate in school field trips and other school related activities?				Yes / No
Is your child's photo permitted to be published in print and on-line?				Yes / No
Names, grade levels, and building of siblings attending Greenon Local Schools:				

II. CUSTODIAL PARENT/GUARDIAN & CONTACT INFORMATION

CUSTODIAL PARENT(S)/ GUARDIAN(S) WITH WHOM THE STUDENT RESIDES:				
Both parents	Independent	Other (please specify):		
Mother only**	Grandparent			
Father only**	Agency			
Shared Parenting	**If Shared Parenting, which parent is listed as the Residential Parent for school purposes:			
**Is this student permitted to be picked-up by Non-Residential Parent?				Yes / No
**Should the Non-Residential Parent be contacted in case of emergency?				Yes / No
**All custody paperwork must be on file. Residential parent is required to notify building of any changes in custody.				
Parent / Guardian Emergency Contact Information				
Name of Parent / Guardian with whom the student resides				
Cell/Alternate Phone:	Work Phone:	Relationship to Child		
Daytime email address:	Place of Employment :			
Name of Parent / Guardian with whom the student resides				
Cell/Alternate Phone:	Work Phone:	Relationship to Child		
Daytime email address:	Place of Employment :			
Name of Parent Non-Residential parent w/ visitation or other parental rights)				
Cell/Alternate Phone:	Work Phone:	Relationship to Child		
Daytime email address:	Place of Employment :			

Alternate Emergency Contacts

In the event of an Emergency, every attempt to contact the Parent or Guardian of the student will be made. Please list additional emergency contact(s) for your student.

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

AUTOMATED MESSAGING INFORMATION (One Call Now)	Changes during the year?
Please list the telephone number that you wish to receive automated messaging announcements on. If you are listing your work number, please check with business first. (_____) _____ - _____	* Address * Phone Numbers * Custody * Emergency Contact If your student(s) has a change during the school year, a Change of Address/Contact form must be filled out and submitted to the building.

III. PARENT/GUARDIAN SIGNATURE AND MEDICAL RELEASE											
Student Name:	Date of Birth:	Grade:									
Physician's Name & Phone:	Preferred Hospital & Phone:										
Dentist's Name & Phone:	Medical Alert (if any):										
List all medications this child is taking (prescription and over-the-counter) and the reason for taking them.											
List allergies to medicine, food or other allergens, and any medical information such as physical impairments and assistive devices, that school staff or emergency personal need to be aware of, attach documentation if necessary.											
<table style="width: 100%; border: none;"> <tr> <td style="text-align: right;">Has your child had Chicken Pox ?</td> <td>Yes</td> <td>No</td> </tr> <tr> <td style="text-align: right;">Has your child received the Varicella (Chicken Pox) vaccine?</td> <td>Yes</td> <td>No</td> </tr> <tr> <td style="text-align: right;">*Has your child received any recent immunizations?</td> <td>Yes</td> <td>No</td> </tr> </table> *(If yes, please attach documentation with dates and types of immunizations received.)			Has your child had Chicken Pox ?	Yes	No	Has your child received the Varicella (Chicken Pox) vaccine?	Yes	No	*Has your child received any recent immunizations?	Yes	No
Has your child had Chicken Pox ?	Yes	No									
Has your child received the Varicella (Chicken Pox) vaccine?	Yes	No									
*Has your child received any recent immunizations?	Yes	No									

Additional Medical Information:

All information is complete and correct. I am the child's custodial parent or legal guardian or I am the student age 18 or older. I grant permission to my child's school, in an emergency when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and it's emergency staff have my authorization to provide treatment which a physician deems necessary for the well being of my child.

Signature(s) of Parent/Guardian	Parent/Guardian Name(s) PRINT	Date Signed
---------------------------------	-------------------------------	-------------

PARENT REFUSAL TO CONSENT FOR MEDICAL TREATMENT

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:

Student's Name:	This section is to be filled out only if you <u>DO NOT</u> give consent for emergency medical treatment of your child.		
Parent/Guardian Signature			
<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Address</td> <td style="width: 30%;">City</td> <td style="width: 40%;">Zip</td> </tr> </table>		Address	City
Address	City	Zip	

If you need assistance in completing this form or accessing any services at or in the Greenon Local School District, contact the Board Office at (937) 864-1202.