# WICKLIFFE CITY SCHOOLS

LEARN. LEAD.SERVE

2221 Rockefeller Road; Wickliffe, Ohio 44092

*Phone*: 440.943.6900 *Fax*: 440.943.7738 *Web*: wickliffeschools.org

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## EMERGENCY MEDICAL AND STUDENT INFORMATION FORM

**(To be completed by the parent or legal guardian)**

Student Name ______________________________________ School: ☐ WES ☐ WMS ☐ WHS Student Grade: ________

Person completing this form __________________________________ Relationship to Student ______________________________

Are custody/guardianship papers on file with the school
as required by Ohio law (ORC 3313.672)? ☐Yes ☐No ☐Not Applicable

Please confirm the demographic information for your household and child on the Infinite Campus Parent Portal. If changes need to be made, please utilize the "update" feature to make necessary changes (subject to approval). If you need assistance, please contact the main office of your child's school prior to submitting this form. *Note that custody/guardianship changes will not be approved via Infinite Campus. Guardianship changes require that official court paperwork be submitted directly to the school main office.*

________ (initial) I have reviewed the information in the Infinite Campus Parent Portal and confirmed that it is correct.

OR

________ (initial) I have reviewed the information in the Infinite Campus Parent Portal and submitted necessary changes.

Please list additional adults who are permitted to pick up your child in the event of an illness or emergency:

Name: ____________________________________________ Name: ____________________________________________

Relationship to child: ________________________________ Relationship to child: ________________________________

Phone #1: (_____)__________________ Phone #1: (_____)__________________

Phone #2: (_____)__________________ Phone #2: (_____)__________________

**- See Reverse -**

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# STUDENT MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of medical treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

**OPTION I (TO GRANT CONSENT)** In the event reasonable attempts to contact me at (____)____________ (phone number) or ______________________ (other parent or guardian) at (____)____________ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. ________________ (preferred physician), (____)____________ (phone) or Dr. ________________ (preferred dentist), (____)____________ (phone) or, in the event the designated practitioner is not available, by another licensed physician or any hospital that is reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two licensed physicians or dentists (if available), concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted: ____________________________________________

____________________________________________

________________________________ ____________________ (DO NOT SIGN IF YOU SIGNED OPTION II)
Signature of Parent or Guardian Date

**OR**

**OPTION II (TO REFUSE CONSENT)** I DO NOT give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

____________________________________________

____________________________________________

________________________________ ____________________ (DO NOT SIGN IF YOU SIGNED OPTION I)
Signature of Parent or Guardian Date