

CANAL WINCHESTER SCHOOLS
STUDENT INFORMATION

STUDENT INFORMATION
2011-2012 School Year

Student's Name:					Grade:	
		<i>Last</i>	<i>First</i>	<i>Middle</i>		
Called Name:		Homeroom:		Gender:	M / F	
Address:		Date of Birth:		Age:		
City:		Apt #/PO Box:		Team #:		
Zip:	County:	Home Phone:		Unlisted	Y or N	

PRIMARY PARENT/GUARDIAN TO CONTACT (Used for emergencies, attendance and important calls)

Name:		Relationship:				
Address:		Daytime Phone:				
		<input type="checkbox"/> Check here to have mail sent to this address if different from student's			(Please use a phone number with no extension or operator)	
City:	State:	Zip:	Type (circle one):	Home	Cell	Work

PARENTS/GUARDIAN LIVING WITH STUDENT (Please complete information below even if same as above)

Mother's Name:		Cell Phone:				
Relationship (circle one):		Natural	Step (married to father)	Guardian (legal)	E-Mail:	
Where Employed:		Work Phone:				
Father's Name:		Cell Phone:				
Relationship (circle one):		Natural	Step (married to mother)	Guardian (legal)	E-Mail:	
Where Employed:		Work Phone:				
If a STEP parent is listed above, are they authorized to pick up your child without prior notice? (circle one):					YES	NO

OTHER NATURAL PARENT NOT LIVING WITH STUDENT


Parent's Name:		Home Phone:				
Address:		Cell Phone:				
City:	State:	Zip:	Work Phone:			
Is the other natural parent listed above authorized to pick up your child without prior notice? (circle one):					YES	NO
Please explain any SPECIAL CUSTODY ISSUES below:						

FAMILY CHILDREN (List first and last name of student's school-aged brothers and sisters)

Name:	M / F	Grade:	Name:	M / F	Grade:
Name:	M / F	Grade:	Name:	M / F	Grade:

AUTHORIZED CONTACTS: Please provide the name and phone number for each person whom you authorize to have your child released to in the event you cannot be reached during the school day. (Please include any **AUTHORIZED STEP-PARENT** even if listed above.) PHOTO identification is required. The authorized contacts must be available during the school day and must have transportation to pick up your child. **Please notify the office immediately if there are any changes to this information.**

Name	Relationship To Student	Daytime Phone:
Name	Relationship To Student	Daytime Phone:
Name:	Relationship To Student	Daytime Phone:

Printed Name of Custodial Parent/Legal Guardian:			
 Signature of Custodial Parent/Legal Guardian:	Date:		

(OVER PLEASE)

Copies: Office - Clinic

**CANAL WINCHESTER SCHOOLS
EMERGENCY MEDICAL AUTHORIZATION**

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be contacted.

PART I OR II MUST BE COMPLETED

Student Name:		Grade:	
	<i>Last</i> , <i>First</i> <i>Middle</i>		

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals to be called:

Family Doctor:		Phone No:	
Family Dentist:		Phone No:	
Hospital/Emergency Room:		Phone No:	

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 the 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 dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history to which a physician and/or staff members should be alerted:

Allergies (please list):	
Medications being taken:	
Any physical impairments or other health issues:	

My signature, in accordance with HIPAA regulations, gives my permission for release of school health information to the school employees and/or other health care providers

Printed Name of Custodial Parent/Legal Guardian:	
Signature of Custodial Parent/Legal Guardian:	Date:

PART II – REFUSAL TO CONSENT: (Do NOT complete this part if you have signed the granting of consent above.)
If you do NOT want to give consent for emergency medical treatment of your child, you MUST sign and date this section of the form. You must also list the actions you want the school to take in the event of illness or injury requiring emergency treatment:

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