## SHEFFIELD-SHEFFIELD LAKE CITY SCHOOLS Emergency Medical Form

Name: Last	First	rst MI		DOB: (mm/dd/yyyy)		-	
Address:		City:		State: OH Zip:		_	
Home Phone:				Cell Phone:		School Use Only	
School:	Grade:			Teacher:	Homeroom:		
List Siblings & School Th	ney Attend						
Please List Any Medical Issues or Allergies:					Does the Student We	ear Contacts or Glasses?	
					Yes No		
		PARENT/G	GUARDI	AN INFORMATION			
PRIMARY ADULT IN HOUSEHOLD				SECON	CONDARY ADULT IN HOUSEHOLD		
Name: Relationship to Student				Name: Relationship to Student			
Address (if different):				Address (if different):			
Day Phone:	y Phone: Evening Phone:			Day Phone: Evening Phone:			
Email:	mail:			Email:			
Employer Name & Phone No.				Employer Name & Phone No.			
Daycare/Babysitter Name: (if applicable)				Phone No:			
		CUSTO	ODIAL II	NFORMATION			
Legal Custodian of Student (Please check appropriate box)							
Mother Fathe	r 🗌 Father 🗆 Shared 🔲 Guardian 🗆 Other 🗆 *Name & Relationship						
EMERGENCY CONTACT INFORMATION  In the case of an emergency, I authorize the school to release my child to one of the following individuals listed below.  *The child will not be released to anyone not listed.							
Name & Phone (Local Contact)  Name & Phone (Local Contact)							
Name & Phone (Local Contact)  Name &			& Phone (Local Contact)				
		that all reasonab	le attemp		<b>)N</b> e above phone numbers, o treatment deemed neces		
Preferred Hospital:	Preferred Doctor:			Preferred Dentist:			
Phone No.:			Phone No.:				
☐ I refuse to consent to a officials to do the following		ent of my child. I		nt of illness/injury requ	uiring emergency treatme	nt, I want the school	
☐ I grant permission for				webpage, Cardinal TV,	newspaper/newsletter.		
Parent Signature & Dat	e:						