Mogadore Local Schools – Student Registration & Emergency Medical Authorization

Purposes: To register student and provide contact information. 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 reached.

Student's Name: _____ (Last) , _____ (First) _____ (Middle) _____ (Suffix) Date of Birth: _____ Grade: _____

Home Address: _____ City: _____ Zip: _____ County _____

Student Resides with: (Check all that apply) ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian ☐ Other:

Student's City of Birth	State	County	Mother's Maiden Name

Mark Order of Contact (1st, 2nd, 3rd, etc.)	Person	Name	Home Phone#	Work Phone#	Cell Phone#
	Mother		( ) -	( ) -	( ) -
	Father		( ) -	( ) -	( ) -
	Stepparent		( ) -	( ) -	( ) -
	Guardian		( ) -	( ) -	( ) -
	Relationship of Guardian to Child:		(i.e. Grandparent, Aunt, Childcare Provider, Neighbor, etc.)		
	Other (A)		( ) -	( ) -	( ) -
	Relationship of A to Child:		(i.e. Grandparent, Aunt, Childcare Provider, Neighbor, etc.)		
	Other (B)		( ) -	( ) -	( ) -
	Relationship of B to Child:		(i.e. Grandparent, Aunt, Childcare Provider, Neighbor, etc.)		

☐ **I GIVE**
☐ **I DO NOT GIVE**
(Check one of the above)

MY PERMISSION for my son/daughter/student to leave school by permission over the phone. (*The persons listed above, in the same order, will be the only persons authorized to give permission for the child to leave school grounds.) Please initial here:

Facts Concerning Student's Medical History* for a Health Care Provider To Be Alerted To:

Date of Last Tetanus Immunization:	Dates of Hepatitis B Immunizations:	(1)	(2)	(3)	Dates of Polio Immunizations:	(1)	(2)	(3)	(4)

Allergies- Medications, Foods, Insect Bites, etc.: Uses **Sting Kit**: ☐Yes ☐No

Medications taken regularly: Uses an **Inhaler**: ☐Yes ☐No

List Any Other Medical Information Here:

* To insure your student's safety, this information may be shared, as necessary, with Faculty and/or Staff of the Mogadore Local Schools

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Please complete only one of the two following options (I or II):

I. Consent to Provide Treatment

In the event of reasonable attempts to contact me or the other parent or guardians listed on the other side of this form have been unsuccessful, I CONSENT TO (1) the administration of any treatment deemed necessary by the preferred doctors indicated, or in the event the designated practitioner is not available, by another 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 two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent or Guardian Name (please print) _____ Signature _____ Date _____

Preferred Physician: Office Phone #: ( ) -

Preferred Dentist: Office Phone #: ( ) -

Preferred Specialist: Office Phone #: ( ) -
(Please note area of specialization)

Preferred Hospital Office Phone #: ( ) -

II. Refusal to Consent to Provide Treatment

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school to take the following action as described below.

Parent or Guardian Name (please print) _____ Signature _____ Date _____

This section must be completed if you choose option II. If necessary you may attach an additional sheet.

Description of action to be taken, please provide detailed instructions: