OUR LADY OF PEACE SCHOOL
1001 39TH STREET NW
CANTON, OHIO 44709

Emergency Crisis Information for <u>each child</u> attending Our Lady of Peace School

Date: _____

Student _____ Grade: _____ Date of Birth:_____

Family Name _____Father_____Mother_____

Address _____City_____Zip_____

Phone_____ Students live with _____ Both Parents
_____ Mother
Student Ethnicity _____ _____ Father
_____ Other _____

Email_____
(to receive news letter, etc...)

FATHER _____ _____
Place of employment Phone (Ext.)
Cell Phone_____

MOTHER_____ _____
Place of employment Phone (Ext.)
Cell Phone_____

OTHER _____ _____

Cell Phone_____

Beginning with the oldest, please list children attending Our Lady of Peace School:

GRADE	LAST NAME	FIRST NAME
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Medical Conditions

Medication Needed: (complete *dispense of medication* form signed by physician for prescription and over-the-counter drugs, cough drops, Tylenol, eye drops, etc...)

_____

_____

Allergies:

_____

Special Needs:

_____

_____

In the event of a serious accident or emergency:

Hospital Preference _____

Physician _____ **Phone** _____

Dentist _____ **Phone** _____

PLEASE COMPLETE BOTH SIDES

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EMERGENCY DATA
Name of person your children may be released to:

Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____
****
Name _____

Relationship_____

Phone_____

Cell Phone _____

Destination_____

Must list at least three contacts

EMERGENCY MEDICAL AUTHORIZATION

Please sign Number 1 or Number 2

1. If we, at the numbers listed, or our authorized physician named above cannot be reached at the time of an emergency, and if immediate observation or treatment seems urgent in the judgement of school personnel, we hereby authorize and direct the school to send the child, properly accompanied, to the hospital or to the physician most easily accessible. I HEREBY GIVE MY CONSENT for the administration of any/all treatment deemed necessary by the hospital or physician.

_____ _____

Date Signature of Parent or Guardian

2. If you do not wish to sign above authorization, please complete the following:

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:_____
_____

_____ _____

Date Signature of Parent or Guardian

PERMISSION FOR SCHOOL SERVICES

(Yes or No) I hereby give permission to have my child leave the classroom to receive services provided by the school nurse such as testing for eye-sight, or for a routine speech and hearing test.

All families will receive a school directory which includes the name of the student, parent names, address and telephone. All families will be listed and you will receive a copy of the directory.

Please **do not** include our telephone number in the school directory. An optional number for contact is _____.

THIS IS FOR SCHOOL USE. THIS DIRECTORY IS VERY IMPORTANT FOR PARENT ASSOCIATION AND OTHER COMMITTEES TO COMMUNICATE TO FAMILIES ABOUT SCHOOL FUNCTIONS AND ANY OTHER IMPORTANT INFORMATION THROUGHOUT THE SCHOOL YEAR. IT IS ALSO A GOOD WAY FOR PARENTS TO BE IN CONTACT WITH EACH OTHER FOR OTHER ACTIVITIES.

PICTURES/VIDEO FOR SCHOOL USE

(Yes or No) I give permission for pictures/video to be taken of my child for school use, to be placed around the school, or for school videos for school use.

(Yes or No) I give permission for pictures of my child to be used in newspaper articles, *Catholic Exponent*, *The Canton Repository* and the *Akron Beacon Journal*.

_____ _____

Date Signature of Parent or Guardian

PLEASE COMPLETE BOTH SIDES