



# Tuscarawas Valley Local School District

2637 Tusky Valley Rd NE  
Zoarville, OH 44656-9692  
330.859.2213

# EMERGENCY MEDICAL

Revised 10.8.14

## STUDENT INFORMATION

STUDENT'S LAST NAME	FIRST NAME	DATE OF BIRTH / /	STUDENT'S CELL, IF APPLICABLE
ADDRESS	CITY	ZIP	STUDENT'S HOME PHONE

Is the above information new since the last time an emergency medical form was filled out?  Yes  No  Not Applicable  
*Please remember to call the school if your child's information changes during the school year.*

If your child is ill or in need of assistance, we will contact the people below in the order listed. The contact will be permitted to pick up your child, if necessary.

PRIMARY CONTACT	PHONE
SECONDARY CONTACT	PHONE
OTHER CONTACT	PHONE

DISTRICT USE	
DISTRICT BUILDING	
<input type="checkbox"/> TVPS	
<input type="checkbox"/> TVIS	
<input type="checkbox"/> TVMS	
<input type="checkbox"/> TVHS	

Primary phone number to be used for PreK-12 Phone Notification System:

GRADE
HOMEROOM

## RESIDENTIAL PARENT INFORMATION

MOTHER'S FIRST NAME			MOTHER'S LAST NAME		
PHONE #1	TYPE	PHONE #2	TYPE	PHONE #3	TYPE
ADDRESS (IF DIFFERENT THAN STUDENT'S)	CITY	ZIP	EMAIL		
FATHER'S FIRST NAME			FATHER'S LAST NAME		
PHONE #1	TYPE	PHONE #2	TYPE	PHONE #3	TYPE
ADDRESS (IF DIFFERENT THAN STUDENT'S)	CITY	ZIP	EMAIL		

BUSING
AM:                      PM:
SHUTTLE:

**STUDENT'S PHOTO HERE (For Office Use)**

## EMERGENCY SCHOOL CLOSINGS

If it should become necessary to close the school during the day for any reason, please indicate where your child should go. IT IS IMPERATIVE THAT THE CHILD AND PERSON AT THE DESTINATION KNOW THE PLAN. Making individual phone calls to parents is an impossibility. Announcements will be made through the phone notification system.

**Please indicate 1st and 2nd choices**  
\_\_\_\_ Ride/walk/or pick up as usual  
\_\_\_\_ Go home with (indicate name):  
\_\_\_\_ Other (please explain):

## RECEIPT OF FORMS

Our family has received, read, and agree to the content of the **Student-Parent Handbook**  
 Yes  No

Our family has received, read, and agree to the **Tuscarawas Valley Local Schools' Acceptable Use Policy**. (May be printed in handbook.)  
 Yes  No

## DIRECTORY INFORMATION

Federal law requires that student "directory information" be released by the district unless there is written objection from the parent/guardian. **This objection must be filed within ten (10) days after the child receives the handbook.** Directory information ordinarily includes the following: **Name**  
**Address and phone**  
**Date and place of birth**  
**Dates of attendance**  
**Photographs**  
**Awards received in school**

STUDENT FIRST NAME	STUDENT LAST NAME	EMERGENCY CONTACT PHONE #1	EMERGENCY CONTACT PHONE #2
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**PERMISSION TO PICK UP**

Please list here the names of anyone permitted to pick up your child from school.	NAME	NAME	NAME
	NAME	NAME	NAME

**TO GRANT CONSENT (CHECK ONE, COMPLETE ONLY ONE PART)**

In the event reasonable attempts to contact the aforementioned persons have been unsuccessful, I hereby give my consent for emergency medical providers to be called. Additional contacts if necessary include:

PRIMARY CARE PHYSICIAN	PHONE
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DENTIST	PHONE
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MEDICAL SPECIALIST	PHONE
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HOSPITAL	PHONE
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This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring the necessity for such surgery, is obtained BEFORE THE SURGERY IS PERFORMED.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted include **(if none, please indicate as such)**:

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**REFUSAL TO CONSENT (CHECK ONE, COMPLETE ONLY ONE PART)**

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action (please indicate):

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**SIGNATURE**

SIGNATURE	DATE
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