Redeemer Christian School
Early Childhood
Emergency Medical Authorization
2026-2027

Student Information

Last Name _____ First Name _____ Middle _____

Preferred Name _____ SSN: _____

Date of Birth: _____ ☐ Male ☐ Female

Primary Family Information

Address _____

City _____ State _____ Zip Code _____

Primary Phone 1 _____ ☐ Unlisted Primary Phone 2 _____ ☐ Unlisted

Father's Information

Last Name _____ First Name _____ Middle _____

Email Address _____ ☐ Personal ☐ Work

Cell Phone _____ ☐ Emergency Contact ☐ Allowed to Pick Up Child

Company Name _____ Job Title _____

Work Phone _____ Ext. _____ Fax _____

Mother's Information

Last Name _____ First Name _____ Middle _____

Email Address _____ ☐ Personal ☐ Work

Cell Phone _____ ☐ Emergency Contact ☐ Allowed to Pick Up Child

Company Name _____ Job Title _____

Work Phone _____ Ext. _____ Fax _____

Secondary Family Information

Address _____

City _____ State _____ Zip Code _____

Primary Phone 1 _____ ☐ Unlisted Primary Phone 2 _____ ☐ Unlisted

Father's Information

Last Name _____ First Name _____ Middle _____

Email Address _____ ☐ Personal ☐ Work

Cell Phone _____ ☐ Emergency Contact ☐ Allowed to Pick Up Child

Company Name _____ Job Title _____

Work Phone _____ Ext. _____ Fax _____

Mother's Information

Last Name _____ First Name _____ Middle _____

Email Address _____ ☐ Personal ☐ Work

Cell Phone _____ ☐ Emergency Contact ☐ Allowed to Pick Up Child

Company Name _____ Job Title _____

Work Phone _____ Ext. _____ Fax _____

Emergency Information

Emergency Contacts Other than Parents: The State of Ohio requires at least TWO emergency contacts other than parents to be listed.

Contact Name _____ Relationship _____

Address _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Contact Name _____ Relationship _____

Address _____

Primary Phone _____ Work Phone _____ Cell Phone _____

Medical Contacts

The State of Ohio requires the name, address, and phone number of the physician and dentist.

Physician's Name _____ Phone _____

Address _____

Dentist's Name _____ Phone _____

Address _____

Hospital _____ Phone Number _____

Insurance _____ Phone Number _____

Medical Information

Does your child have any health problems or concerns the school personnel should be aware of?

☐ Yes ☐ No

If yes, what are they?

_____

Is your child under a doctor's care on an ongoing basis? ☐ Yes ☐ No

If yes, please specify.

_____

Has your child had any surgery? ☐ Yes ☐ No

If yes, please indicate the type of surgery and the child's age when the surgery was performed?

_____

Does your child take any medication regularly? ☐ Yes ☐ No

If yes, name of medication _____

Amount taken _____ How often? _____

Will your child be taking this medication at school? ☐ Yes ☐ No

If yes, authorization form must be completed and on file in the office.

Does your child have any allergies, either food or environmental? ☐ Yes ☐ No

If yes, please specify.

_____

Does your child wear glasses? ☐ Yes ☐ No Contacts? ☐ Yes ☐ No

If yes, corrections are needed for: ☐ Board Work ☐ Class Work ☐ All the Time

Pickup Information

List any persons, other than parents, to whom your child may be released. Please list two. Under NO circumstances will your child be released to anyone other than those listed without further authorization!

Name _____ Phone _____ License _____

Address _____

Relationship _____ Notes _____

Name _____ Phone _____ License _____

Address _____

Relationship _____ Notes _____

Please complete either Part 1 or Part 2 below. Do NOT complete both!

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by afore-mentioned doctor or dentist, or in the event designated 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, concurrent in the necessity for such surgery, are obtained prior to the performance of such surgery.

Part 1: To Grant Consent

I give Redeemer Christian School my permission to transport my child (name of child) _____ to (hospital, clinic) _____ for emergency medical or dental care, or to the nearest available source of assistance.

Parent Signature _____ Date _____

OR

Part 2: Refusal to Grant Consent

I do not give permission to Redeemer Christian School to transport my child (name of child) _____ for emergency medical or dental care. In the event of an illness or injury, which requires emergency medical treatment, I wish the following action to be taken: _____

Parent Signature _____ Date _____