Defiance DD
County Board of Developmental Disabilities
UNITE. INSPIRE. BECOME.

# 2023-2024 Family Information Sheet

**Student Information**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| First Name | | Middle Name | | Last Name | | Sex | | Date of Birth mm/dd/yyyy | / / |
| Social Security Number | | Phone Number | ( ) - | Medicaid Number | | Email Address | | | |
| Address | | | | | | | | | |
| Student Lives with: | Both Parents | Father | Mother | Guardian | Stepmother | Stepfather | | | |
| Racial/Ethnic Origin: | White | Hispanic | Black | Asian | Other: | | | | |

**Parent/Guardian Information**

| Name (First, Middle, Last) | Address | Phone Number | | Place of Employment | Work Phone Number |
|---|---|---|---|---|---|
| Father: | | H: | C: | | ( ) - |
| Mother:<br>Maiden Name: | | H: | C: | | ( ) - |
| Step Parent/Guardian: | | H: | C: | | ( ) - |

***If parents are divorced/separated:***

| | | | | |
|---|---|---|---|---|
| *Who has legal (court appointed) custody? | | | | |
| If joint custody, who has residential custody? | | | | |
| *Is there a restraining order? | Yes No | Against Whom? | | |

*A copy of these documents MUST be provided to the school.

List **TWO LOCAL** adults (other than parents/guardians) who will assume temporary care of your child in case of emergency or who they can be released to:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Name | | Relationship | | Address | | Phone | |
| Name | | Relationship | | Address | | Phone | |

***Siblings***

| Name | Age | Grade | School Attending |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Your student may accompany their class on school organized field trips?** | | | | | Yes | No |
| **Student's picture and video may be used for educational, promotional, or other program purposes?** | | | | | Yes | No |
| **May participate in swim program?** | | | | | Yes | No |
| **Does your student know how to swim?** | | | | | Yes | No |
| **May be included in class roster (Name, parent(s) name, date of birth, and phone number)?** | | | | | Yes | No |
| **Keep up with everything Defiance County Board of DD related, like Delays and Closures with Call & Text Alerts!** | Yes | No | Call | Text | Both | ( ) - |

_____ _____

Signature of Parent/Guardian Date

**For Office Use Only**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Sent to EMIS | | Entry Date | | Withdrawal Date | | Date of Last MFE | | School District of Residence | |

**For Teacher Use Only**

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# Emergency Medical Authorization Form

Student Name: _____
Address: _____
Phone Number: _____ Cell Phone Number: _____

**Purpose:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

| | | | |
|---|---|---|---|
| Mothers Name | | Phone Number | |
| Father's Name | | Phone Number | |
| Other's Name | | Phone Number | |

Name of Relative or Childcare Provider:

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Address | | Phone Number | |

**Part I or II Must be Completed**

**Part I- To Grant Consent**

I hereby give consent for the following medical providers and local hospital to be called:

| | | | |
|---|---|---|---|
| Doctor | | Phone Number | |
| Dentist | | Phone Number | |
| Medial Specialist | | Phone Number | |
| Local Hospital | | Phone Number | |

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

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted to:

_____
_____

Signature of Parent/Guardian Date

Address

**Part II- Refusal to Consent**

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

_____
_____

Signature of Parent/Guardian Date

Address