

**Rochester School District Medical Authorization  
& Student Household Contact Form**

Elementary

Grade: \_\_\_\_\_

Teacher: \_\_\_\_\_

Bus# \_\_\_\_\_ Walk \_\_\_ Car \_\_\_

Please **PRINT** Neatly

Student's Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle MM DD YYYY

Gender (Circle One): Male / Female Nickname (Optional): \_\_\_\_\_

Address Where Student is Living: \_\_\_\_\_ Apt # (If Applicable) \_\_\_\_\_  
Number Street City State Zip

Mailing Address (if different) \_\_\_\_\_ Apt # (If Applicable) \_\_\_\_\_  
Number Street City State Zip

<b><u>Parent/ Legal Guardian who student lives with:</u></b>					Home Ph# _____	
<b>Name:</b>						
<small>Last</small>	<small>First</small>	<small>Middle</small>	<small>Relationship</small>	<small>Cell Ph#</small>	<small>Work Ph#</small>	
<b>Name:</b>						
<small>Last</small>	<small>First</small>	<small>Middle</small>	<small>Relationship</small>	<small>Cell Ph#</small>	<small>Work Ph#</small>	
<b>Address:</b> _____				Apt # (If Applicable) _____		
<small>Number</small>	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>		
<b>Parent E-Mail Address:</b> _____						

<b><u>Parent/ Legal Guardian who student does not live with (if applicable):</u></b>					Home Ph# _____	
<b>Name:</b>						
<small>Last</small>	<small>First</small>	<small>Middle</small>	<small>Relationship</small>	<small>Cell Ph#</small>	<small>Work Ph#</small>	
<b>Name:</b>						
<small>Last</small>	<small>First</small>	<small>Middle</small>	<small>Relationship</small>	<small>Cell Ph#</small>	<small>Work Ph#</small>	
<b>Address:</b> _____				Apt # (If Applicable) _____		
<small>Number</small>	<small>Street</small>	<small>City</small>	<small>State</small>	<small>Zip</small>		
<b>Parent E-Mail Address:</b> _____						

**Emergency and Dismissal Contact**

Please list two readily available people you would like for us to have on file related to your child who will assume temporary care of your child if you cannot be reached first or permission to dismiss.

- |                     |                      |                  |                       |  |                                |                                |
|---------------------|----------------------|------------------|-----------------------|--|--------------------------------|--------------------------------|
| _____               | _____                | _____            | _____                 | _____                                      | _____                          | _____                          |
| <small>Last</small> | <small>First</small> | <small>M</small> | <small>Gender</small> | <small>Relationship to the student</small> | <small>Phone Number #1</small> | <small>Phone Number #2</small> |
- |                     |                      |                  |                       |  |                                |                                |
|---------------------|----------------------|------------------|-----------------------|--|--------------------------------|--------------------------------|
| _____               | _____                | _____            | _____                 | _____                                      | _____                          | _____                          |
| <small>Last</small> | <small>First</small> | <small>M</small> | <small>Gender</small> | <small>Relationship to the student</small> | <small>Phone Number #1</small> | <small>Phone Number #2</small> |

**Medical Information**

**Signing this form** authorizes Frisbie Memorial Hospital to provide a free dental screening to your child. This will be done by a Registered Dental Hygienist and given to all students **grades 1-3**. This also authorizes Frisbie's Dental Program to release screening results for the purpose of follow up care to a dental professional when needed.

Check here for refusal ONLY \_\_\_ Allergy to metal \_\_\_yes \_\_\_no. Allergy to Latex \_\_\_yes \_\_\_no

**In case of an accident or serious illness and I cannot be reached, I hereby authorize the school personnel to secure medical help for my child.**

Name of Student's Physician: \_\_\_\_\_ Tel.# \_\_\_\_\_

**Please list any health conditions/treatments** including allergies (be specific), medications, chronic health conditions (asthma, seizures, etc.), glasses/vision concerns, hearing concerns, significant injuries etc. This information may be shared with those people who work with your child. If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Special circumstance – Please attach current legal documentation/information (custody issues, history, family circumstances, ect.)**