

**CATTARAUGUS-LITTLE VALLEY CSD**  
**EMERGENCY MEDICAL INFORMATION AND RELEASE FORM:**

Each year our school updates emergency information for all students. Please complete the questionnaire below for the students in your household and return it to the Main Office on or before the first day of school. Since the medical information being provided may be different for each child, it is necessary that a separate form be used for each child. This form will be available for field trips during this school year.

**\*\*\* Please Note: Parental/Guardian signature is required to place this information in the Cattaraugus Little Valley District Power School. \*\*\***

**Legal Name of Student** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **Grade/Teacher** \_\_\_\_\_

**Parent(s) or Guardian:** \_\_\_\_\_  
**Street Address:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_

**Father's Place of Work:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Mother's Place of Work:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**CONTACT/EMERGENCY INFORMATION:**

**Contact 1:**  
**Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Cell Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Work Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Email Address:** \_\_\_\_\_

**Contact 2:**  
**Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Cell Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Work Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Email Address:** \_\_\_\_\_

**Does Contact 2 reside with student:**  YES  NO  
**If NO: Should contact 2 receive separate parent mailings:**  YES  NO

**Mailing Address:** \_\_\_\_\_  
**Mailing City, State, Zip Code:** \_\_\_\_\_

**Contact 3:**  
**Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_  
**Home Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Cell Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Work Phone:** \_\_\_\_\_  Check box to **EXCLUDE** from Automated Calling  
**Email Address:** \_\_\_\_\_

**Does Contact 3 reside with student:**  YES  NO  
**If NO: Should contact 3 receive separate parent mailings:**  YES  NO

**Mailing Address:** \_\_\_\_\_  
**Mailing City, State, Zip Code:** \_\_\_\_\_

**\*\*Additional Automatic Notification Preferences (email, text messaging) can be set through you parent portal account.**

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**EMERGENCY MEDICAL INFORMATION AND RELEASE FORM:**

**Personal Physician:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

Health/Accident Insurance Company: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

**Medical Information: Additional information not listed on Health Record**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies requiring Benadryl or Epi Pen :     Yes         No  
If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_

**Authorization Consent for Medical Treatment of a Minor:**  
I authorize the Cattaraugus-Little Valley Central School personnel to transfer, admit, and authorize any hospital or physician to render treatment to my child or legal ward in the event of accident or illness. I also give my permission for trained adult leaders to administer first aid without delay and /or seek professional medical treatment. I expect every reasonable effort to be made to contact the parent, legal guardian and/or family physician. In case of emergency, I give permission for a field trip leader to secure proper treatment.

\_\_\_\_\_  
(Parent /Guardian Signature)

**Emergency Closing Information**  
If the school should close early due to weather or other related issues...my child/children \_\_\_\_\_ are to follow these instructions: (Please list a daytime phone number where you or your childcare provider can be reached if there is an early dismissal).

\_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

\*\* Recent changes to NYS Education Law require that body mass index (BMI) and weight status groups be included as part of the student's school health examination in grades PreK/or K, 2<sup>nd</sup>, 4<sup>th</sup>, 7<sup>th</sup>, and 10<sup>th</sup>. We will be reporting our students' weight status groups. Only summary information is sent, no names and no information about individual students are sent. However, you may choose to have your child's information excluded from this survey report. If you do not wish to have your child included, you need to complete and sign a form stating this. Please contact any of the School Nurses for this form. \*