



**ILION CENTRAL SCHOOL DISTRICT  
EMERGENCY RELEASE & NOTIFICATION FORM  
PLEASE COMPLETE ALL THE INFORMATION REQUESTED**

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Homeroom Teacher** \_\_\_\_\_

**School (Please check)**     **Barringer**             **Remington**             **Jr.-Sr. High School**

PARENT/GUARDIAN INFORMATION			
<b>Father/Guardian</b> <input type="checkbox"/> <b>Primary Residence</b> Name: _____ Address: _____ _____ _____ Place of Employment: _____ Home Phone: _____ Cell/Alternate Phone: _____ Work Phone: _____ Email Address: _____ _____ Other relationship if applicable: _____	<b>Mother/Guardian</b> <input type="checkbox"/> <b>Primary Residence</b> Name: _____ Address: _____ _____ _____ Place of Employment: _____ Home Phone: _____ Cell/Alternate Phone: _____ Work Phone: _____ Email Address: _____ _____ Other relationship if applicable: _____		

*Phone numbers - Global Connect Automatic Notification (The system can not dial extensions.)*

RELEASE/ADDITIONAL CONTACT INFORMATION			
If we cannot reach you by phone, we need the names of <u>local</u> people and/or relatives who will assume responsibility for your child. Please Note: We will only release your child to the people listed below. To ensure the safety of your child, we will request photo identification of the person picking up your child. If someone other than those listed below will be picking up your child, you must send a signed and dated request for such a release. List a minimum of two people who will assume temporary care of your child.			
Name	Relationship	Address	Phone

OTHER CHILDREN IN HOUSEHOLD – infant through grade 12			
Name	Date of Birth	Grade	Teacher

**MEDICAL/POWER OF ATTORNEY**

**EMERGENCY POWER OF ATTORNEY**

In the event of an accident or sudden or unexpected illness of my child, if I cannot be contacted, I authorize the school staff to call the physician named below and to follow his instructions. Should the named physician not be available, I further authorize, in my place and in my stead, the school to seek the services of any qualified physician and to transport my child to the physician's office or hospital for treatment including x-rays, laboratory tests or whatever medical or surgical procedures are necessary on an emergency basis. I hereby authorize such physician to render such medical and surgical treatment and agree to pay the customary fees or charges for such treatment.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING:**

Allergies: \_\_\_\_\_

Previous Injuries or Surgery: \_\_\_\_\_

Blood Type \_\_\_\_\_ Insurance Company \_\_\_\_\_

Local Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Office Telephone \_\_\_\_\_

Local Dentist Name \_\_\_\_\_ Phone \_\_\_\_\_

I understand my obligation to request and complete a new form when any information on this form changes. I understand that the numbers and email address that I provide under Global Connect Automatic Notification will be used for both emergency and non-emergency purposes. I understand that information that I provide under Release/Additional Contact Information will not receive Global Connect Notifications unless I elect to also record the number under Cell/Alternate number.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_