



EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911.

Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

| | | | | | |
|---|---------|-----------------------|----------------|--|-------------|
| Last: | First: | Middle: | Date of Birth: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Grade: |
| School Name: | ID No.: | Teacher or Counselor: | | Bus # (AM): | Bus # (PM): |
| <input type="checkbox"/> Student has medical alert information on file. See page 2 for details. | | | | | |

PARENT/GUARDIAN CONTACT INFORMATION

Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school. A non-custodial parent has the right to be listed as an emergency contact unless a court order or other legal document stating otherwise has been presented to the school.

| | | | | | |
|---------------|---------------------------------------|-----------|-----------|--|--|
| Last: | First: | Middle: | Telephone | | |
| | | | Home: | | |
| Number: | Street: | Apt.#: | | | |
| | | | Work: | | |
| City: | State: | Zip: | | | |
| | | | Other: | | |
| Relationship: | <input type="checkbox"/> Resides with | Language: | E-mail: | | |
| Last: | First: | Middle: | Telephone | | |
| | | | Home: | | |
| Number: | Street: | Apt.#: | | | |
| | | | Work: | | |
| City: | State: | Zip: | | | |
| | | | Other: | | |
| Relationship: | <input type="checkbox"/> Resides with | Language: | E-mail: | | |
| Last: | First: | Middle: | Telephone | | |
| | | | Home: | | |
| Number: | Street: | Apt.#: | | | |
| | | | Work: | | |
| City: | State: | Zip: | | | |
| | | | Other: | | |
| Relationship: | <input type="checkbox"/> Resides with | Language: | E-mail: | | |
| Last: | First: | Middle: | Telephone | | |
| | | | Home: | | |
| Number: | Street: | Apt.#: | | | |
| | | | Work: | | |
| City: | State: | Zip: | | | |
| | | | Other: | | |
| Relationship: | <input type="checkbox"/> Resides with | Language: | E-mail: | | |

OTHER CONTACT INFORMATION

Please list four people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the school day.

| Name of Person | Relationship | Language | Telephone |
|----------------|--------------|----------|-----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

* Please remember to sign page 2.



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|--------------|---------|-----------------------|----------------|--|--------|
| Last: | First: | Middle: | Date of Birth: | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | Grade: |
| School Name: | ID No.: | Teacher or Counselor: | Bus # (AM): | Bus # (PM): | |

SIBLINGS ATTENDING THE SAME SCHOOL (complete if applicable).

Name(s): _____

CURRENT HEALTH CONDITIONS

Below check any current health condition that may require attention during the school day. Also complete and submit Health Information form SS/SE-71 if your child has health conditions that require attention during the school day. **See below for medical alert information currently on file.**

| | |
|---|--|
| <input type="checkbox"/> allergies (be specific) | <input type="checkbox"/> hemophilia |
| <input type="checkbox"/> foods _____ | <input type="checkbox"/> physical disability (be specific) _____ |
| <input type="checkbox"/> medicines _____ | |
| <input type="checkbox"/> bee sting or insect bite _____ | <input type="checkbox"/> respiratory (be specific) _____ |
| <input type="checkbox"/> other _____ | |
| <input type="checkbox"/> asthma | <input type="checkbox"/> seizures |
| <input type="checkbox"/> cancer | <input type="checkbox"/> vision problems (be specific) _____ |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> glasses <input type="checkbox"/> contacts |
| <input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) | <input type="checkbox"/> other (be specific) _____ |
| <input type="checkbox"/> heart problems (be specific) _____ | |

List all medications and dosages your child receives on a continual basis:

MEDICAL ALERT INFORMATION ON FILE

PHYSICIAN INFORMATION

My child's medical care is provided by: _____ (name of doctor, clinic, or HMO) _____ (telephone)

My child's medical coverage is provided by: _____ (health insurance company, assistance program, HMO, etc.) _____ (telephone)

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____