



EMERGENCY CARE INFORMATION

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

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

STUDENT NAME		School:	Bus No:
Last		ID No:	Grade Level:
First		Date of Birth:	Teacher/Counselor:
Middle		Sex (✓): <input type="checkbox"/> M <input type="checkbox"/> F	
		Social Security No:	Language Spoken at Home:

Student resides with (✓): FATHER MOTHER BOTH LEGAL GUARDIAN

FATHER Language _____ ADDRESS _____ TELEPHONE _____

Last _____ Home (____) _____

First _____ Work (____) _____

Middle _____ Car/Pager (____) _____

MOTHER Language _____ ADDRESS _____ TELEPHONE _____

Last _____ Home (____) _____

First _____ Work (____) _____

Middle _____ Car/Pager (____) _____

LEGAL GUARDIAN Language _____ ADDRESS _____ TELEPHONE _____

Last _____ Home (____) _____

First _____ Work (____) _____

Middle _____ Car/Pager (____) _____

LIST 2 PERSONS WE SHOULD CALL IN AN EMERGENCY IF THE PARENT(S)/GUARDIAN CANNOT BE REACHED.

Name of Person	Relationship	Language Preferred	Telephone
1. _____	_____	_____	1. (____) _____
2. _____	_____	_____	2. (____) _____

THE FOLLOWING PERSONS ARE AUTHORIZED TO PICK UP MY CHILD:

1. _____

2. _____

BEFORE AND AFTER SCHOOL CARE (Complete if applicable)

Name of Provider: _____ Telephone (____) _____

PHYSICIAN INFORMATION

My child's medical care is provided by _____ Telephone (____) _____
(Name of doctor/clinic/HMO, etc.)

My child's medical care is covered by _____ Telephone (____) _____
(Health insurance company, assistance program, HMO, etc.)

HEALTH INFORMATION

Check (✓) any current health condition that may require attention during the school day.

<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"/> respiratory (be specific) _____
<input type="checkbox"/> bee sting/insect _____	<input type="checkbox"/> seizures _____
<input type="checkbox"/> other _____	<input type="checkbox"/> vision problems (be specific) _____
<input type="checkbox"/> asthma	<input type="checkbox"/> glasses <input type="checkbox"/> contacts
<input type="checkbox"/> cancer	<input type="checkbox"/> other (be specific) _____
<input type="checkbox"/> diabetes	
<input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s)	
<input type="checkbox"/> heart problems (be specific) _____	

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

Obtain medication forms from school for any medication required during the school day.

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

☞ PARENT/GUARDIAN SIGNATURE: _____ DATE: _____