

## Emergency/Health School Form 2010-2011

**Family Name:** \_\_\_\_\_

Form Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

- Yes, I agree to have my name, address, and telephone number included in the School Directory published in early September.**
- No, I do not want my information published.**

**Emergency Phone Broadcasting System.** (check one) \_\_\_ home \_\_\_ work or \_\_\_ cell phone.

Mother/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Address: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Check the Parent/Guardian to notify first: \_\_\_ Father \_\_\_ Mother \_\_\_ Other (Complete below)

Other: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Work: \_\_\_\_\_

**List two alternate individuals who you assign temporary care of your child if you cannot be reached. Indicate whether or not you authorize these individuals to have permission to transport your child:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Has permission to transport: \_\_\_ Yes \_\_\_ No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Has permission to transport: \_\_\_ Yes \_\_\_ No

*In the event that your child is involved in an emergency situation at school and needs to be transported to a hospital, the answer to the following questions are essential for immediate effective treatment.*

**List information for enrolled children from the oldest to youngest:**

1.) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_ Male \_\_\_ Female \_\_\_\_\_ Child's Grade  
Date of Birth: \_\_\_\_\_

Does your child wear corrective lenses? \_\_\_ No \_\_\_ Yes (Please indicate) \_\_\_ Contacts \_\_\_ Glasses

Are there any health problems, drug/food allergies, or medicines the child is taking that the school should know about: \_\_\_ No \_\_\_ Yes (Describe below)

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(continued on reverse side)

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2.) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Child's Grade \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Does your child wear corrective lenses? \_\_\_\_\_ No \_\_\_\_\_ Yes (Please indicate) \_\_\_\_\_ Contacts \_\_\_\_\_ Glasses \_\_\_\_\_

Are there any health problems, drug/food allergies, or medicines the child is taking that the school should know about: \_\_\_\_\_ No \_\_\_\_\_ Yes (Describe below)

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3.) First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Child's Grade \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Does your child wear corrective lenses? \_\_\_\_\_ No \_\_\_\_\_ Yes (Please indicate) \_\_\_\_\_ Contacts \_\_\_\_\_ Glasses \_\_\_\_\_

Are there any health problems, drug/food allergies, or medicines the child is taking that the school should know about: \_\_\_\_\_ No \_\_\_\_\_ Yes (Describe below)

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### Email Correspondence (optional)

Home email address: \_\_\_\_\_

### Medical Information

Physician's Name: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Office Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Identification number or covered employee: \_\_\_\_\_

Group number: \_\_\_\_\_ and/or Plan number: \_\_\_\_\_

**In case of accident or serious illness, I request that the school contact the individuals I have listed in the order as indicated on the previous page. Since in an emergency, these telephone numbers are called in order until there is a response, I agree to keep these numbers up to date. If the school is unable to reach my contacts, I hereby authorize the school to use their own best judgment in sending my child to the hospital or doctor most easily accessible. Please note that every attempt will be made to call the physician indicated below:**

**Parent/  
Guardian Signature:** \_\_\_\_\_ **Date signed:** \_\_\_\_\_