

Emergency/Health School Form 2011-2012

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 use: Please circle

Inhaler: Yes or No

EpiPen: Yes or No

Does your child have food allergies: Yes or No

Does your child wear corrective lenses? ___ No ___ Yes (if yes) ___ Contacts ___ Glasses

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

(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 use: Please circle

Inhaler: Yes or No EpiPen: Yes or No Does your child have food allergies: Yes or No

Does your child wear corrective lenses? _____ No _____ Yes (if yes) _____ Contacts _____ Glasses _____

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

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

Does your child use: Please circle

Inhaler: yes or no EpiPen: Yes or No Does your child have food allergies: Yes or No

Does your child wear corrective lenses? _____ No _____ Yes (if yes) _____ Contacts _____ Glasses _____

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

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 above:

Parent/

Guardian Signature: _____ Date signed: _____