

EMERGENCY INFORMATION

Date _____

PARENTS/GUARDIANS

Please complete all the information requested below. This information is needed in order to update files and respond to emergency situations while your child is in school. Please remember to notify us of any changes in this information.

Student Name _____ Grade _____ Date of Birth _____

Student Address (include city and zip code) _____ Home Phone _____ Bus Number _____

Child lives with: _____ Both Parents _____ Mother _____ Father _____ Other _____

Parent's e-mail address _____ Should your child be wearing glasses in school? ____Yes ____No

Father's Name _____ Father's Home/Cell # _____ Father's Employer _____ Father's Work # _____

Mother's Name _____ Mother's Home/Cell # _____ Mother's Employer _____ Mother's Work# _____

NAME OF LOCAL PERSON TO CONTACT IF PARENTS ARE NOT AVAILABLE (MUST BE COMPLETED):

Name		Relation	Address		Phone Number
BROTHERS AND SISTERS IN SCHOOL					
Name	Building	Grade	Name	Building	Grade

Is there anyone with whom you do not permit your child to leave the building? EXPLAIN: _____

Is there anyone in the building we can send homework with when your child is ill: Name _____ Grade _____

HEALTH DATA

Medical conditions the school nurse should be aware of: _____

Asthma? Yes ___ No ___ Requires asthma medication: _____

Severe bee sting reaction? Yes ___ No ___ Latex Allergy? Yes ___ No ___ Other Allergies? _____

For Allergies Listed Above: Requires an Epi-pen? Yes ___ No ___ Requires Benadryl? Yes ___ No ___

Other medical conditions: _____

Medication student is taking: _____

Communicable diseases currently, or in the past year: _____

The school nurse has my permission to administer the following to my child: (Please mark with an X if you give permission. No mark will mean that no permission is given.)

_____ Ibuprofen _____ Tylenol _____ Aleve _____ Tums _____ Cough Drop _____ Benadryl _____ First Aid

I HEREBY RELEASE THE SCHOOL DISTRICT, THE SCHOOL NURSE, OR OTHER EMPLOYEES OF THE DISTRICT FROM ANY LIABILITY AS A RESULT OF THIS TREATMENT. BY SIGNING THIS FORM, I GIVE PERMISSION FOR THE NURSE TO SHARE MEDICAL INFORMATION WITH DISTRICT PERSONNEL USING A CONFIDENTIAL MEDICAL PRIORITY LIST TO BETTER CARE FOR MY CHILD.

Signature of parent /guardian _____ Date _____

Child's Doctor _____ Phone Number _____ Child's Dentist _____ Phone Number _____

EMERGENCY RELEASE

IF EMERGENCY TREATMENT IS REQUIRED AND PARENTS CANNOT BE CONTACTED IMMEDIATELY, YOUR SIGNATURE IN THE SPACE PROVIDED EMPOWERS THE SCHOOL AUTHORITIES TO EXERCISE THEIR OWN JUDGMENT IN CALLING THE PHYSICIAN INDICATED ABOVE, OR IF NOT AVAILABLE, TO TRANSPORT THE CHILD TO THE HOSPITAL EMERGENCY ROOM OF YOUR PREFERENCE.

Hospital Preference _____ Parent/Guardian Signature _____ Date _____

EMERGENCY DISMISSAL PROCEDURES

In case of an emergency early dismissal your child should know what to do. Please write instructions in the event that we dismiss early. Teachers will keep this on file and use as a reminder. These procedures should, if at all possible, avoid the use of the school phone.

_____ Child should go home as usual. _____ Child should follow these procedures: (Write procedures here or on back if necessary).