

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 _____

Cell phone numbers: Mother's _____ Father's _____

Emergency Contact Name & Phone Numbers: _____

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

Parent's e-mail addresses _____

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

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

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

Name _____ 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: _____

HEALTH DATA

Medical conditions the school nurse should be aware of: _____

Asthma? Yes ___ No ___ Requires asthma medication _____ Severe bee sting reaction? Yes ___ No ___

Other allergies? _____ 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 _____ Roloids _____ 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. MEDICAL INFORMATION WILL BE SHARED WITH SCHOOL STAFF AS NEEDED TO BETTER CARE FOR YOUR 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 procedures listed on bottom/back of sheet.