



Student Emergency Contact and Health Information Consent Form

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on both sides of this form carefully and accurately. Please type or use ink and print clearly and legibly.

STUDENT: _____ Male: _____ Female: _____ Grade _____

 Last Name First Middle

 Home Address (Primary Residence) City Zip Home Phone Birthdate

 Mailing Address, if different than above Lives with (circle below):
 Both Parents Mother Father Legal Guardian

MOTHER/GUARDIAN: _____

 Last Name First Employer Work Phone

 Home Address, if different than above City Zip Phone Cell Phone

FATHER/GUARDIAN: _____

 Last Name First Employer Work Phone

 Home Address, if different than above City Zip Phone Cell Phone

Are there any court mandated custody / visitation orders limiting access to this student? Yes: _____ No: _____

(If Yes, please attach a copy of the legal order and list those named therein): _____

Please list siblings and their ages:

Name	Age	Name	Age	Name	Age

AUTHORIZED CONTACTS: Please list the names of relatives/neighbors/friends in close proximity to the school to whom we may release your child or contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS, OR ADULTS LISTED ON THIS PAPER. In selecting someone to whom you authorize the release of your child, consider: (a) Would your child feel safe and comfortable with this person? (b) Could this person care for your child for several days? (c) Is this person prepared to handle any special medical needs required by your child?

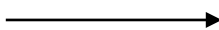
I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work or Cell Phone

I declare that the information on this form is true and correct. I will notify the school immediately of any changes to be made to this form.

Parent/Guardian Signature: _____ Date: ____ / ____ / _____ Relationship: _____

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Student Emergency Contact - Health Information – Consent Form

Student Emergency Contact and Health Information Consent Form

STUDENT NAME: _____ Birthdate: ____ / ____ / ____
 Last Name First Name Middle

MEDICAL HEALTH INFORMATION Medication: Does your child require medication? (Circle one) Yes No

Do you give permission for your child to be administered: Acetaminophen (Tylenol) Yes No
 Ibuprofen Yes No
 Non-prescription cough drops Yes No
 Antihistamines (Benadryl, etc.) Yes No
 Antacids (Tums, etc.) Yes No

If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file. Please list medications below:

Medication	Dosage	Hour(s) Given

Health Insurance Information: (Please check the type of coverage you have.): _____ Family Health Insurance _____ No Health Insurance

Health Plan/Group Name: _____ Policy No. _____

Date of last health/physical exam: _____ Date of last dental checkup _____

Physician/Health Care Provider: _____ Phone No. _____

Dentist _____ Phone No. _____

Vision and/or Hearing Problems: (Please circle all that apply.) Glasses Contacts For reading All the time

Date of last eye exam _____ Eye Care Provider _____ Phone #: _____

Does your child wear a hearing aid? _____ If yes, which ears? _____

Medical Conditions: (Please circle all that apply.)

Severe allergies requiring: Epi-pen Benadryl

Severe allergies: Food / Environmental Stinging Insects / Bees Medicines / Drugs Other _____

Please explain all allergies listed above: _____

Current asthma? Yes No Uses inhaler On daily medication Asthma action plan

Current seizures? Yes No

Diabetes? Yes No Insulin dependent

Behavior problems: _____ Movement limitations: _____

Immunizations: _____ Date Given _____

Recent illness, hospitalization or surgery – dates and descriptions: _____

Medical condition which might require care or accommodation at school: _____

EMERGENCY TREATMENT AUTHORIZATION

In the event of an emergency, I request the school contact me, If they are not able to reach me and emergency care is considered necessary, I give permission to the school personnel to seek emergency medical care, including transportation to and care at the closest emergency facilities, and I assume financial responsibility for such.

Signature of Parent or Guardian: _____ Date: ____ / ____ / ____

CARE PROVIDER RELEASE

I give permission to the school nurse / guidance counselor / principal to contact my child's medical or dental care providers for the purpose of sharing or requesting pertinent information relating to my child's health and care, or treatment received.