STUDENT EMERGENCY CONTACT INFORMATION

Student Information

Student name ____ Student ID # ___________________ Gender M F

Home address ____ Birthdate ____________________ Bus rider? Y N

____ Grade ______ Homeroom _______ Bus # _________

Home phone _______________________________ Hispanic/ Latino? Y N Race __________________________

Guardian Information

Father's name ____ Call 1st 2nd

Father's address ____ Home phone ______________________________

____ Mobile phone ____________________________

Father's employer ____ Work phone ______________________________

Father's email ____ Lives with student? Y N

Mother's name ____ Call 1st 2nd

Mother's address ____ Home phone ______________________________

____ Mobile phone ____________________________

Mother's employer ____ Work phone ______________________________

Mother's email ____ Lives with student? Y N

Emergency Contacts

Please list the names of relatives/friends /neighbors 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 PARENTS, GUARDIANS OR ADULTS LISTED ON THE FORM. PLEASE PROVIDE A MINIMUM OF 2 ALTERNATE CONTACTS.

I 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 at school.

Alternate emergency Contact(s) Name	Relationship to student	Home phone	Mobile phone	Work phone

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

☐ I consent the release of information for immunizations, physical and/or dental exams by my family physician's office.

In the event that my child requires immediate emergency medical attention, I understand that the district will make every reasonable attempt to contact me or the alternates listed above. I cases where this type of emergency treatment is required for my child, and parent, guardian or alternate contact cannot be located, I give my permission for the district to obtain treatment from the closest medical facility, and will not hold the district or its professional staff responsible for any financial obligations incurred.

____ _____________ ______________________________

Parent/ guardian signature Date Relationship to student

In compliance with the Family Education Rights and Privacy Act (FERPA), the information disclosed in this document may be shared with others who are responsible for the care and well-being of your child.

MEDICAL INFORMATION AND CONSENT

Student name ______________________ Student ID# ______________ Date of Birth ______________

Medical Contact and Insurance Information

Health Plan/ Group name ______________________ Plan Policy No. ______________________

Insurance Company ______________________ Insurance Phone No. ______________________

Physician/ Health Care Provider ______________________ Physician Phone No. ______________________

Dentist ______________________ Dentist Phone No. ______________________

Medical Conditions Mark all that apply:

☐ Allergies	☐ Heart/ Vascular Disorders	☐ Gastrointestinal	☐ Neurological Disorders
☐ Arthritis/ Rheumatic Disease	☐ Connective Tissue Disorder	☐ Genitourinary Disorders	☐ Orthopedic Disorders
☐ Asthma	☐ Cystic Fibrosis	☐ Hearing Problems	☐ Psychiatric Conditions
☐ Attention Deficit Disorder	☐ Diabetes	☐ Hypertension	☐ Seizure Disorders
☐ Birth Defects/ Developmental Disorder	☐ Eating Disorder	☐ Immunosuppressive Conditions	☐ Vision Deficit/ Color Blindness
☐ Bleeding Disorders	☐ Endocrine	☐ Malignancies	☐ Weight Disorder
☐ Other Medical Condition: Describe ______________________			

Annual Health Update

☐ Serious illness, injury or hospitalization in the past year ☐ Still under treatment

Describe: ______________________

If you checked any of the above Medical Conditions, please explain: ______________________

Name(s) of Physician(s) treating student for above condition: ______________________

List of Medications student takes for above conditions: ______________________

Will it be necessary for student to receive medication during school hours? ☐ Yes ☐ No

Is so, please specify: ______________________

Immunizations during past year *(List exact date of immunization)*

Immunization ______________ Date ______________ Immunization ______________ Date ______________

Immunization ______________ Date ______________ Immunization ______________ Date ______________

Date of last physical ______________ Date of last Tetanus Booster ______________

Medication and Exam Consent

I give permission for my child to be administered the following by school health personnel (* Approved by School Doctor)

Tylenol (Generic)	☐Yes ☐ No	Throat Lozenge	☐Yes ☐ No	Antibiotic Ointment	☐Yes ☐ No
Ibuprofen	☐Yes ☐ No	Benadryl	☐Yes ☐ No	Hydrocort Cream 0.5%	☐Yes ☐No
Antacid	☐Yes ☐ No	Physical Exam	☐Yes ☐ No	Dental Exam	☐Yes ☐ No