STUDENT'S NAME _____ School Year _____
Last First M.I.

EMERGENCY INFORMATION

Please complete entire form. Signature required.

Date of Birth _____ ❑ Male ❑ Female Homeroom/Teacher _____ Grade _____ Bus. No. _____

Home Address _____

Email Address _____

Father's/Guardian's Name _____ Place of Occupation _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____ Cell/Beeper (_____) _____

Mother's/Guardian's name _____ Place of Occupation _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____ Cell/Beeper (_____) _____

With whom does the child reside? _____

Local persons who have *AGREED* to care for child when parents cannot be reached:

1._____ Relationship _____ Phone (_____)_____

2._____ Relationship _____ Phone (_____)_____

3._____ Relationship _____ Phone (_____)_____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary, including transporting my child to the nearest medical facility.

Family Physician _____ Phone (_____) _____

Date _____ **Signature of Parent/Guardian** _____

ADMINISTRATION OF MEDICATION
Medication, prescribed or over-the-counter, will be given in the schools only upon a written order from the family physician and written parental permission. Forms are available through the school nurse. Medication must be brought to the school nurse by the parent or guardian in a pharmacy-labeled bottle.

MEDICAL EXCUSES
Extended excuses from gym and all other normal children's activities will be granted only upon a written statement from the child's Physician. Crutches and other appliances in school are not allowed unless accompanied by a doctor's note.

HEALTH UPDATE

State health problems (allergies – including food or medication – seizures, asthma, vision or hearing loss) or physical limitations: _____

_____

State any medications your child is taking at home or school: _____

Condition: _____

_____

If your child was hospitalized during the past year, give date and reason: _____

Sibling's Name	D.O.B.	School		Sibling's Name	D.O.B.	School

OFFICE USE ONLY

Updated changes to be copied and sent to building principal, teacher, secretary, and administration office –3-hole punched.

Name _____ Student ID# _____