

sport(s): \_\_\_\_\_



### EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

#### STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Bus No.:	
School Name:		ID No.:	Teacher or Counselor:			

#### HEALTH INFORMATION

Below check any current health condition that may require attention during the school day. Also complete and submit Health Information form SS/SE-71 if your child has health conditions that require attention during the school day.

<input type="checkbox"/> allergies (be specific) <input type="checkbox"/> foods _____ <input type="checkbox"/> medicines _____ <input type="checkbox"/> bee sting or insect bite _____ <input type="checkbox"/> other _____ <input type="checkbox"/> asthma <input type="checkbox"/> cancer <input type="checkbox"/> diabetes <input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) <input type="checkbox"/> heart problems (be specific) _____	<input type="checkbox"/> hemophilia <input type="checkbox"/> physical disability (be specific) _____ <input type="checkbox"/> respiratory (be specific) _____ <input type="checkbox"/> seizures <input type="checkbox"/> vision problems (be specific) _____ <input type="checkbox"/> glasses <input type="checkbox"/> contacts <input type="checkbox"/> other (be specific) _____
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List all medications and dosages your child receives on a continual basis:

#### CONTACT INFORMATION

Student resides with: (x)  Father  Mother  Both  Guardian  
 Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school, unless a court order or other legal document states otherwise. It is your responsibility to provide a copy of that document to your child's school.

Father  Guardian

Last	First	Middle	Telephone
Number Street		Apt #	Home ( ) _____
City		State	Work ( ) _____
		Zip	Other ( ) _____

Language: \_\_\_\_\_ E-mail: \_\_\_\_\_

Mother  Guardian

Last	First	Middle	Telephone
Number Street		Apt #	Home ( ) _____
City		State	Work ( ) _____
		Zip	Other ( ) _____

Language: \_\_\_\_\_ E-mail: \_\_\_\_\_

Please list three persons we may call if the parent(s) or guardian cannot be reached who have your permission to make decisions concerning your child in the event of an emergency. Please check the box if this person also has your permission to pick up your child from school.

Name of Person	Relationship	Language	Telephone
<input type="checkbox"/> _____	_____	_____	( ) _____
<input type="checkbox"/> _____	_____	_____	( ) _____
<input type="checkbox"/> _____	_____	_____	( ) _____

BEFORE- AND AFTER-SCHOOL CARE (complete if applicable). Please check the box if this person has your permission to pick up your child from school.

Name of Provider: \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

#### PHYSICIAN INFORMATION

My child's medical care is provided by \_\_\_\_\_ (name of doctor, clinic, or HMO) Telephone ( ) \_\_\_\_\_

My child's medical coverage is provided by \_\_\_\_\_ (health insurance company, assistance program, HMO, etc.) Telephone ( ) \_\_\_\_\_

The school has my permission, in an emergency when I cannot be contacted, to take my child to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

PARENT or GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_