Click here to reset the student specific fields on these forms. Parent/Guardian information will not be affected by this RESET function.

FAIRFAX COUNTY PUBLIC SCHOOLS

SHOW Instruction box

EMERGENCY CARE INFORMATION

of an emergency, the school staff will contact 911.
de to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last:	First:	Middle:	Date of Birth:	Gender ☐ M ☐ 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.

- ☐ allergies (be specific)
  - ☐ foods _____
  - ☐ medicines _____
  - ☐ bee sting or insect bite _____
  - ☐ other _____
- ☐ asthma
- ☐ cancer
- ☐ diabetes
- ☐ hearing problems ☐ hearing aid(s)
- ☐ heart problems (be specific) _____
- ☐ hemophilia
- ☐ physical disability (be specific) _____
- ☐ respiratory (be specific) _____
- ☐ seizures
- ☐ vision problems (be specific) _____
  - ☐ glasses ☐ contacts
- ☐ other (be specific) _____

You can only save the EMPTY form (unless you have purchased and installed the Adobe Acrobat software).

HIDE Instruction box

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.

Phone numbers, type 10 numbers only!

☐ Father ☐ Guardian

Last | First | Middle

Number Street | Apt #

City | State | Zip

Language: _____ E-mail: _____

Home (___) _____
Work (___) _____
Other (___) _____

☐ Mother ☐ Guardian

Last | First | Middle

Number Street | Apt #

City | State | Zip

Language: _____ E-mail: _____

Telephone
Home (___) _____
Work (___) _____
Other (___) _____

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
☐				(___)
☐				(___)
☐				(___)

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)

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

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: _____

SS/SE-3 (7/03) Distribution: White-School Canary- Clinic Copy- Copy as needed for other school activities.

Please print and sign two copies of this form