

Student Information and Emergency Medical Form

2017-2018

Homeroom Teacher:

**Student Information**

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Residence Address: \_\_\_\_\_

\_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

**Parental Information**

Custodial Parent(s): \_\_\_\_\_

Change (if new custody is in effect, please provide school with copy of court documents)

\_\_\_\_\_

Parent Address: \_\_\_\_\_

\_\_\_\_\_

Parent Phone: \_\_\_\_\_

Parent Cell: \_\_\_\_\_

Additional Cell Numbers: \_\_\_\_\_

Sibling(s): \_\_\_\_\_

**Homeless Status:** Please let us know if any of these situations pertain to your family:

- Doubled Up (living with another family due to economic hardship, loss of home, or other similar situation)
- Living in Hotel/Motel     Living in Shelter (homeless, Every Woman's House, etc.)     Unsheltered (living in car, etc.)

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if any court orders are in effect restricting non-custodial parents or others from contact with this student.

Emergency Information

Student Name:

Date of Birth:

Emergency Contact Information: List two neighbors or relatives who will assume care of your child if you cannot be reached. Those designated below, other than parents, are authorized to pick up my child from school in an emergency (list in order of preference):

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Emergency Number Mom: \_\_\_\_\_ Dad: \_\_\_\_\_

----- ADDITIONAL EMERGENCY CONTACTS -----

1. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child \_\_\_\_\_ Daytime phone \_\_\_\_\_ Cell \_\_\_\_\_

2. Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship to child \_\_\_\_\_ Daytime phone \_\_\_\_\_ Cell \_\_\_\_\_

Do not release my child to: \_\_\_\_\_

Emergency Medical Authorization: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

My child has the following allergies or medical condition(s) and may/may not need medication(s) for treatment:

\*ALLERGIES: (specify) \_\_\_\_\_ EPIPEN Yes or No \*SEIZURES: \_\_\_\_\_ diastat Yes or No

\*ASTHMA: \_\_\_\_\_ Inhaler Yes or No \* ADD/ADHD: \_\_\_\_\_ Medication Yes or No \*DIABETES: \_\_\_\_\_ insulin or oral meds

\*SKIN CONDITIONS (list): \_\_\_\_\_ OTHER (specify): \_\_\_\_\_

Current Medications (list): \_\_\_\_\_

To ensure the health and safety of my child at school, I authorize the information listed above to be shared with necessary staff members. Yes \_\_\_\_\_ No \_\_\_\_\_

Part I - To Grant Consent: I hereby give consent for the following medical care providers and local hospital to be called.

Preferred Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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Part II - Refusal to Consent: I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action as they are reasonably able to do so:

\_\_\_\_\_

\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_