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: _____