



# Pupil Health & Emergency Information

School Year \_\_\_\_\_

**IF ANY OF THIS INFORMATION CHANGES DURING THE SCHOOL YEAR, I WILL NOTIFY THE SCHOOL IMMEDIATELY.**

ID# \_\_\_\_\_

StudentServices/080 11/09

Student's Name \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_  
Last Name First Name Middle

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone (\_\_\_\_) \_\_\_\_\_  
Unlisted? \_\_\_\_Y \_\_\_\_NFather's Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_Mother's Name \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_  
Employer \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_Person With Whom Pupil Lives \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_  
(if other than parent) Employer \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
E-Mail \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Month/Year of Last Tetanus Shot \_\_\_\_\_

Allergies (Food, Medication or Other) \_\_\_\_\_

Medical Condition Which May Require Treatment Over Several Days \_\_\_\_\_

My Child Takes The Following Medication(s) on a Regular Basis: \_\_\_\_\_

	Name of Medication	Medical Dosage	Frequency	Reason
<b>MEDICAL HISTORY</b> Does your child have any of the following:	Vision Problems <input type="checkbox"/>	Hearing Problems <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Speech Problems <input type="checkbox"/>
	Dizziness or fainting <input type="checkbox"/>	Convulsions <input type="checkbox"/>	Allergies (please specify) <input type="checkbox"/>	Heart Problems <input type="checkbox"/>
	Food Restrictions (please specify) <input type="checkbox"/>	_____		
	Other (please specify) <input type="checkbox"/>	_____		

IN CASE OF EMERGENCY, I GIVE MY PERMISSION TO THE FOLLOWING PERSON(S) TO TAKE RESPONSIBILITY FOR THE PHYSICAL CUSTODY OF MY CHILD:	NAME	RELATIONSHIP	ADDRESS	PHONE
	NAME	RELATIONSHIP	ADDRESS	PHONE
	NAME	RELATIONSHIP	ADDRESS	PHONE

My child may not be released to: \_\_\_\_\_  
(If a parent, you must file a custody order from court).**EMERGENCY AUTHORIZATION:** IN AN EMERGENCY, I REQUEST THE SCHOOL TO CONTACT ME. IF THE SCHOOL IS UNABLE TO CONTACT ME, I HEREBY AUTHORIZE THE SCHOOL TO MAKE SUCH ARRANGEMENTS AS SEEM NECESSARY. FURTHERMORE, I AUTHORIZE THAT MY CHILD BE TAKEN TO THE NEAREST HOSPITAL, OR THE NEAREST HOSPITAL, AND THE PHYSICIAN(S) TO RENDER EMERGENCY MEDICAL TREATMENT TO MY CHILD. I WILL ACCEPT FULL FINANCIAL RESPONSIBILITY FOR CHARGES CONNECTED WITH THE USE OF AN AMBULANCE AND CHARGES CONNECTED WITH THE HOSPITAL CARE.

NAME OF INSURANCE COMPANY \_\_\_\_\_ POLICY # \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_