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**FAMILY/STUDENT HEALTH AND EMERGENCY INFORMATON**

1. PARENT/GUARDIAN \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
 EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_

2. PARENT/GUARDIAN \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_  
 EMPLOYMENT \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 CELL PHONE \_\_\_\_\_

**PERSONS TO CONTACT IF PARENTS ARE NOT AVAILABLE:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_  
 NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

In the event of an emergency (earthquake or other disaster) release my children to: *(Complete on if different than above)*

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_  
 NAME OF FAMILY DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_  
 HOSPITAL PREFERENCE \_\_\_\_\_ PHONE \_\_\_\_\_  
 HEALTH INSURANCE (Check)  
 Private/Group \_\_\_\_\_ Medicaid \_\_\_\_\_ No Health Insurance \_\_\_\_\_ HMO – Managed Care \_\_\_\_\_

THE SCHOOL IS REQUIRED TO HAVE CURRENT AND COMPLETE IMMUNIZATION RECORDS ON EACH CHILD BY THE FIRST DAY OF SCHOOL.

The school will never dispense internal medication at the request of a student. NO ASPIRIN/TYLENOL WILL BE DISPENSED. In response to parental request, the school will arrange that medicine which is clearly labeled, be stored and dispensed by a responsible adult. Often this request is a temporary one. If you wish to request this service on a regular basis, please explain: \_\_\_\_\_

The school will assist students who have minor accidents or ailments, by using ordinary external supplies such as bandages, antiseptic solution, adhesive tape, cold packs, etc. If you do not wish any of these supplies used for your child, please explain: \_\_\_\_\_

- Financial assistance is available, for those who qualify, for dental and/or eye care, shoes, & immunizations. If you would like more information on this, please contact your school principal.
- Vision and hearing screening will be made annually.
- Scoliosis (curved spine) screening will be ordered during the fall of each school year for both boys and girls in grades 6 through 8. If you do not want your child screened, please notify the school.

**AUTHORIZATION FOR SCHOOL OFFICIALS IN CASE OF EMERGENCY:**

I authorize school officials to secure emergency treat if I cannot be reached. I will assume responsibility for expenses incurred.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

CHILDREN FROM OLDEST TO YOUNGEST

1. **Student's Name** \_\_\_\_\_  
Last First Middle Age Grade  
Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

List health conditions or disabilities \_\_\_\_\_

List medication your child is allergic to \_\_\_\_\_

Other allergies (food, seasonal, band aids, other) \_\_\_\_\_

Medications taken routinely \_\_\_\_\_ as needed \_\_\_\_\_

Any vision/hearing problems? Yes / No (wear glasses, contacts, hearing aid)  
Explain \_\_\_\_\_

Child has had a physical exam in the last two years? Yes \_\_\_ No \_\_\_ Child has had a dental exam in the last year? Yes \_\_\_ No \_\_\_

Child has received an immunization or boosters in the last year? Yes \_\_\_ No \_\_\_ Type \_\_\_\_\_ Date \_\_\_\_\_

2. **Student's Name** \_\_\_\_\_  
Last First Middle Age Grade  
Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

List health conditions or disabilities \_\_\_\_\_

List medication your child is allergic to \_\_\_\_\_

Other allergies (food, seasonal, band aids, other) \_\_\_\_\_

Medications taken routinely \_\_\_\_\_ as needed \_\_\_\_\_

Any vision/hearing problems? Yes / No (wear glasses, contacts, hearing aid)  
Explain \_\_\_\_\_

Child has had a physical exam in the last two years? Yes \_\_\_ No \_\_\_ Child has had a dental exam in the last year? Yes \_\_\_ No \_\_\_

Child has received an immunization or boosters in the last year? Yes \_\_\_ No \_\_\_ Type \_\_\_\_\_ Date \_\_\_\_\_

3. **Student's Name** \_\_\_\_\_  
Last First Middle Age Grade  
Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

List health conditions or disabilities \_\_\_\_\_

List medication your child is allergic to \_\_\_\_\_

Other allergies (food, seasonal, band aids, other) \_\_\_\_\_

Medications taken routinely \_\_\_\_\_ as needed \_\_\_\_\_

Any vision/hearing problems? Yes / No (wear glasses, contacts, hearing aid)  
Explain \_\_\_\_\_

Child has had a physical exam in the last two years? Yes \_\_\_ No \_\_\_ Child has had a dental exam in the last year? Yes \_\_\_ No \_\_\_

Child has received an immunization or boosters in the last year? Yes \_\_\_ No \_\_\_ Type \_\_\_\_\_ Date \_\_\_\_\_