



Emergency Information

This form is to be completed by the Parent/Guardian. The form must be submitted to the Records Office by **Wednesday, August 1, 2018**. In an emergency, school will contact the Parents first. It is the Parent's responsibility to update the information on this form. Please print.

Student Information				
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Last	First	Middle	Date of Birth	Grade
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Parent/Guardian Contact Information				
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Parent Name	Last	First	Lives with student ___yes ___no	Home Telephone
			Relationship:	
Address		Apt. #		Cell Telephone
City		State		Zip
Work Telephone				
Email:				
Parent Name	Last	First	Lives with student ___yes ___no	Home Telephone
			Relationship:	
Address		Apt. #		Cell Telephone
City		State		Zip
Work Telephone				
Email:				

Other Contact Information				
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Please list at least two other adults we may call if the parent(s) cannot be reached in an emergency. Individuals listed below also have your permission to pick your daughter up from school during the school day or in the event of an emergency school closing.

Name		Relationship to Student		
Home Phone	Work Phone		Cell Phone	
Name		Relationship to Student		
Home Phone	Work Phone		Cell Phone	
Name		Relationship to Student		
Home Phone	Work Phone		Cell Phone	
Name		Relationship to Student		
Home Phone	Work Phone		Cell Phone	

Parent /Guardian Signature _____ Date _____

Please turn over and complete medical information section on the back of this form.

Student Health Information

Please check any current or chronic health conditions that may affect your daughter during the school day.

Allergies/Environmental	Yes		Bone/Joint/Muscular Disorder	Yes	
Allergies/Food*	Yes		Diabetes	Yes	
Allergies/Insect Stings or Bee	Yes		Dizziness or Fainting	Yes	
Allergies/Medications*	Yes		Digestive/Bowel Problems	Yes	
Allergies/Others*	Yes		Hearing Issues/Hearing Aid*	Yes	
Asthma/Breathing Problems*	Yes		Heart-related Illness	Yes	
Bladder/Kidney Disorder	Yes		Seizure or Epilepsy*	Yes	
Bleeding/Clotting Disorder	Yes		Vision or Eye Disorder*	Yes	

If your daughter has a medical condition for which she has a health plan, please submit a copy of the health plan with this form. Students who take medications during the school day must submit the Physician's Request to Self-Medicate and Parent Authorization to Self-Medicate forms prior to bringing the medicine to school. These forms must be updated and submitted annually each school year.

Provide details regarding:

Allergies: Allergic to the following foods _____

Allergic to the following medicines _____

Does your daughter carry an EpiPen? ___ Yes ___ No

Asthma: Does your daughter carry an inhaler? ___ Yes ___ No If yes, specify _____

What triggers your daughter's asthma attack? _____

Describe the symptoms your daughter experiences before or during an asthma attack. Check all that apply:

___ Coughing ___ Shortness of breath ___ Wheezing ___ "Tightness" in chest ___ Breathing hard/fast ___ Feeling tired/weak

Other _____

Diabetes: ___ Type 1 ___ Type 2

Please contact your daughter's Guidance Counselor or the Dean of Students to complete a Diabetic Care plan which will be followed during the school day.

Hearing: Does your daughter wear a hearing aid? ___ Yes ___ No

Does your daughter need to be seated near the teacher in order to hear well? ___ Yes ___ No

Seizure: Seizure history _____

If she takes medication for seizures, please list: _____

Vision: Does your daughter wear ___ Glasses ___ Contact Lenses Does your daughter need to be seated at the front of the classroom? ___ Yes ___ No

If you checked Yes to any other medical condition or your daughter has a medical condition not listed, please explain.

I give permission to the school to share information relevant to my daughter's health condition with school personnel and emergency medical professionals when necessary to meet her health and safety needs.

Parent/Guardian Signature _____ Date _____