

Student Emergency Information

Student: _____ **Grade:** ____ **Year:** ____
Last First Middle

Address: _____ Male ___ Female ___

Phone: _____ **HR Teacher:** _____ **D.O.B:** ___/___/___

Father's/Legal Guardian's Full Name Work Phone

Father's/Legal Guardian's Home Address/Zip Code Home Phone

If different than above

Mother's/Legal Guardian's Full Name Work Phone

Mother's/Legal Guardian's Home Address/Zip Code Home Phone

Father's/Legal Guardian's email Mother's/Legal Guardian's email

List up to four other persons to whom your child may be released. Your signature authorizes this release.

Name Phone

Name Phone

Name Phone

Name Phone

Parent/Guardian Signature: _____ **Date:** _____

ANNUAL HEALTH UPDATE

HEALTH PROBLEMS: Diagnosed by a Health Care Provider. Check those that apply:

| | | | |
|--|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> Weight/eating disorder | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Blind/Poor Vision | <input type="checkbox"/> Dental Problems |

Other Problems: _____

Allergies to: _____

Wears glasses for reading Wears glasses all the time Wears Contacts

Is there a health problem that would alter full participation in the school or PE program? YES NO

Is there a medical reason for special seating in the classroom? YES NO

Is the student taking medication on a regular basis? YES NO

If yes, what medication[s]: _____

Type of Health Insurance: MA _____ HMO _____ OTHER _____

Name of Physician: _____ Phone: _____

Address:

PLEASE CONTACT THE SCHOOL NURSE IF YOU WOULD LIKE A CONFERENCE