2021-22 STUDENT EMERGENCY INFORMATION

STUDENTS NAME (LAST,FIRST, MIDDLE)	**PLEASE FILL OUT ONE PAPER FOR EACH INDIVIDUAL STUDENT**
STUDENT CELL PHONE	GRADE
ADDRESS (STREET-CITY-STATE-ZIP)	
PREFERRED CONTACT EMAIL FOR HOUSEHOLD	

Mother Stepmother Grandmother Guardian (Please circle one) Lives with student Y or N In case of Emergency please indicate priority to call_____	Father Stepfather Grandfather Guardian (Please circle one) Lives with student Y or N In case of Emergency please indicate priority to call_____
NAME	NAME
CELL PHONE	CELL PHONE
WORK PHONE	WORK PHONE
HOME PHONE	HOME PHONE
PARENT'S EMAIL	PARENT'S EMAIL

OTHER EMERGENCY CONTACTS – LIST NAMES OF PERSONS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED AND YOUR CHILD NEEDS TO LEAVE SCHOOL DUE TO ILLNESS. PLEASE INDICATE BY PRIORITY!

Name :_____Phone:_____Relationship:_____
Name :_____Phone:_____Relationship:_____
Name :_____Phone:_____Relationship:_____
Name :_____Phone:_____Relationship:_____
Name :_____Phone:_____Relationship:_____
Physician/Hospital Contact Info:_____

MEDICAL INFORMATION (please check Yes or No)

Allergic Reactions Yes No If yes, type of allergies_____
Asthma Yes No If yes, type of medication taken_____
Diabetes Yes No If yes, type of treatment_____
Seizure Disorders Yes No If yes, what type if seizures_____
Medications taken regularly_____
**Note: If your child needs to take medication during the school day please inform our nurse with details.

May your child take _____Tylenol_____Benadryl_____Sudafed_____Other_____

OTHER MEDICAL CONDITIONS

_____
_____
_____
_____

OTHER PEOPLE ALLOWED TO CHECK OUT YOUR CHILD

_____
_____
_____

Over the Counter Medication Authorization Form

Parent/Guardian:

In order for us to best serve your student(s), we must have this form completed and returned to the office at the beginning of the school year.

We do have some OTC medications available for students here at school. No over the counter medications will be given to a student without this form on file with your signature AND allergy information.

OTC medications available include Ibuprofen, Tylenol, Tums, Benadryl, Nasal decongestant, cough drops, and eye drops. By signing this form, you are indicating that it is okay for your student to receive any of the above.

Name of Student_____

Grade_____ **Teacher**_____

I hereby give permission for_____ to take any of the above mentioned medications at school. I further understand that any school employee who administers this medication to my child in accordance with written instructions from the parent shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such medications.

_____ _____

Signature of Parent/Guardian **Date**

Please provide the following information for the school nurse to maintain for her record. Please indicate in what order you want each person to be called.

Parent/Guardian's Name (1)_____ (2)_____

Mother/Father (Circle One) **Mother/Father (Circle One)**

Other Contact Name (3)_____

(1) Contact Numbers (H)_____(W)_____(C)_____

(2) Contact Numbers (H)_____(W)_____(C)_____

(3) Contact Numbers (H)_____(W)_____(C)_____

ALLERGIES:_____

MEDICAL CONDITIONS / IMPORTANT INFORMATION:

_____

_____

If your student requires any daily or 'as needed' prescription medication during school hours, please see the nurse for a prescription authorization form. No prescription medication will be administered without one.