LIST NAMES OF CHILDREN

Last First

Last First

Last First

Last First

FAMILY/STUDENT HEALTH AND EMERGENCY INFORMATION

1. PARENT/GUARDIAN ______
   ADDRESS ______ PHONE ______
   EMPLOYMENT ______ WORK PHONE ______
   E-MAIL ADDRESS: ______ CELL PHONE: ______

2. PARENT/GUARDIAN ______
   ADDRESS ______ PHONE ______
   EMPLOYMENT ______ WORK PHONE ______
   E-MAIL ADDRESS: ______ 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 only if different from the 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 ______

THE SCHOOL IS REQUIRED TO HAVE CURRENT AND COMPLETE IMMUNIZATION RECORD 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 the 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 on a regular basis, please explain: ______

______

The school will assist students who have minor accidents or aliments, 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 screenings will be made annually.

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

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

DATE ______ PARENT SIGNATURE ______

LIST 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 medications your child is allergic to _______________________________________

Other allergies (food, seasonal, bandaids, other)___________________________________

Medication taken routinely__________________________ as needed_______________

Any vision/hearing problems? Yes / No (wears 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 medications your child is allergic to _______________________________________

Other allergies (food, seasonal, bandaids, other)___________________________________

Medication taken routinely__________________________ as needed_______________

Any vision/hearing problems? Yes / No (wears 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 medications your child is allergic to _______________________________________

Other allergies (food, seasonal, bandaids, other)___________________________________

Medication taken routinely__________________________ as needed_______________

Any vision/hearing problems? Yes / No (wears 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__________