STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information below and return to school immediately.

Student Name ____
Last   First   Middle Init.

Street Address ____________________ State__________ Zip__________

Home Phone ____________________

Grade Sex: Male ❑ Female ❑ Date of Birth: / /

Primary Language ____________________

Does your child have health insurance? Yes ❑ No ❑

Health Insurance Company ____________________ Policy Number ____________________

Parent 1/Guardian ____________________ Place of employment ____________________

Home Address ____________________ State __________ Zip__________

Work Address ____________________ State __________ Zip __________

Phone: Home ____________________ Work ____________________ Cell ____________________

Parent 2/Guardian ____________________ Place of employment ____________________

Home Address ____________________ State __________ Zip__________

Work Address ____________________ State __________ Zip __________

Phone: Home ____________________ Work____________________ Cell____________________

Name/Grade of sisters/brothers in school building ____________________

Please indicate names of others who will assume responsibility and provide transportation for your student in case of illness/injury/emergency evacuation:

Name/Relationship____________________

Daytime Phone: ____________________

Name/Relationship____________________

Daytime Phone: ____________________

In case of medical emergency, the school will attempt to contact parent/guardian before calling student's

primary care provider. Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name____

Telephone Number____________________

My preference is to have my child treated at _________________________________ medical facility, if possible.

Please list all medications that your child takes:

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I understand that this information is confidential. However, federal law permits information in the school health record to be shared with school officials on a "need to know" basis and with a very limited number of other persons, including those who could help in an emergency. In other circumstances, my consent will be required. I give permission to exchange information with my child's health care provider. I understand that I can limit or revoke this consent at any time.

Signature____Date_________________