2016-17 Emergency and Health Information

Student Name: ____

Birthdate: ________________ **Grade:** _________ **Student's Cell Phone:** ________________

Home Phone: ______________________________

Parent/Guardian 1st Contact: ____________________________________

1st Contact's Employer: ____

Work Phone: ________________ **Cell Phone:** ____________________ **Text:** *Yes / No*

Parent/Guardian 2nd Contact: ____________________________________

2nd Contact's Employer: ____

Work Phone: ________________ **Cell Phone:** ____________________ **Text:** *Yes / No*

Family Physician: ______________________ **Phone:** __________________________

Relative/Friend that may be contacted in an emergency if parents/guardians cannot be contacted:

____

Name *Relationship* *Phone*

____

Name *Relationship* *Phone*

<u>Health Related Questions</u>:

1. **Does your child have allergies? If so, what is the allergy and how is it treated?**

   No *Yes* ____

2. **Circle any condition(s) pertaining to this student:**

   frequent headaches *near sightedness* *asthma*

   seasonal allergies *frequent upset stomachs* *other* ________________

3. **Are there any health conditions that would prevent your child from participating in PE class and/or recess activities?** ______________________________________

4. **Is your child taking any medications either at home, or here during school*?** *No* *Yes*

   If yes, name the medication ____

   *If the medication needs administered at school, a permission form must be submitted.

Parent/Guardian's Signature: ____