



# Emergency Information & Authorization Form 2018-2019

Please complete this form and return to Health Office BEFORE the first day of school.

### Section 1. CONTACT INFORMATION

Child's Name: Last		First	Middle
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth Date: Month / Day / Year		Age:      Class:
Address:		Home Phone:	
Father's Name: Last		First	Cell Phone:
Address: (If Different than child)		Home Phone:	
Place of Employment:		Work Phone:	
Address of Employment:			
Mother's Name: Last		First	Cell Phone:
Address: (If Different than child)		Home Phone:	
Place of Employment:		Work Phone:	
Address of Employment:			

### Section 2. ALTERNATIVE CONTACTS

**If my child has to be taken home because of a MINOR ILLNESS and I cannot be reached, please call:**

Name:	Phone:
Address:	Relationship:
Name:	Phone:
Address:	Relationship:

### Section 3. EMERGENCY CARE

**In an EMERGENCY when you cannot reach either parent, I authorize the school to call:**

Physician's Name:	Phone:
Address:	
Dentist's Name:	Phone:
Address:	

### Section 4. HEALTH SURVEY

1. Has the student had any immunizations, including tetanus injection, since September 1<sup>st</sup>, 2017?  YES  NO

1b. If YES, please specify:

2. Has the student had any illnesses, serious injuries, operations, or other communicable diseases since September 1<sup>st</sup>, 2017?  YES  NO

2b. If YES, please specify with dates:

3. Are there any conditions such as heart disease, epilepsy, diabetes, liver or kidney disease, or other known handicaps of which the school should be aware in order to plan an appropriate program?  YES  NO

3b. If YES, please specify:

4. Does the student have any allergies?  YES  NO      4b. If YES. Please specify:

5. Date of Last Dental Exam:      6. Date of Last Ear Exam:      7. Date of Last Eye Exam:

8. Current medications and dosages:

### Section 5. ADDITIONAL COMMENTS

Additional Comments:

### Section 6. AUTHORIZATION

Parent's Signature	Date
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