Center for Student Learning - Emergency Information

_____
(Last Name) (First Name) (Middle Initial)

Grade ____ Section_____ Date of Birth_____ Male ____ Female ____ School Year_____

Home Address _____ Home Phone # _____
(Street Address)

_____
(City) (State) (Zip Code)

Father/Guardian Name _____Employer _____

Email_____ Cell # _____ Work # _____

Mother/Guardian Name _____Employer _____

Email_____ Cell # _____ Work # _____

Student Email _____Student Cell# _____

Parents in household (Circle) 1 2 Child resides with _____

Other persons who are authorized to act for parent/guardian or pickup student in an emergency

1. Name_____ Relationship _____ Home # _____

Cell #_____

2. Name_____ Relationship _____ Home # _____

Cell #_____

Health Services Mandated by State Law

(Check Yes or No to indicate your consent to each item below)

Physical Examinations (Grades 6, 9) The physical will include the examination of skin, eyes, ears, nose, throat, teeth, gums, heart, lungs, abdomen, genitalia, neuromuscular system, skeletal system, nutritional and emotional status, blood pressure and pulse.

Performed by family doctor _____ Performed by the school doctor, physician's assistant, or nurse practitioner _____

Dental Examinations (Grade 7) Performed by family dentist _____ Performed by school dentist _____

(Other screenings such as height/weight, vision, hearing, and scoliosis will be done on students in specific grades, as mandated by the state.)

Does your child have vision or hearing problem? Yes _____ No _____ If yes, please explain _____

Does your child wear glasses? Yes _____ No _____ Contacts? Yes _____ No _____

Does your child have a severe allergy (bee sting, food, medication, other) Yes _____ No _____

If yes, type of allergy _____.

If yes, what treatment is necessary? Medication _____Hospitalization _____ Both_____

Check consent for school nurse or personnel to administer medication during school day. The School nurse is authorized to decline to administer a medication if the situation warrants.

Acetaminophen (Tylenol) Yes ___ No ___ Ibuprofen Yes ___ No ___ Benadryl Yes___ No___

Pepto Bismol Yes ___ No ___ Sudafed Yes ___ No ___ Tums Yes___ No___

Family Doctor _____ Phone# _____

Does your child have a special health problem or physical limitation that the school nurse or teacher should know about?

Yes___No ___ Explain _____

I have read this form completely and herby confirm that the above information is correct and give permission for my child to have those examinations and medications to which I have consented on this form.

Parent's/Guardian's Signature _____ Date _____