

Emergency Information Form

		/ /	M F	Yes or No
Last Name	First Name	Birthday	Sex	Ride Bus?
Student's Address		Home Phone #	Grade/Teacher	

Place a number in the blank to the left of each phone number listed below to indicate your order of preference to call in case of an emergency. Please notify the school when any of this information changes.

Mother _____ Home Ph _____ Cell Ph _____
 First Last
Place of Employment _____ Work Ph _____

Father _____ Home Ph _____ Cell Ph _____
 First Last
Place of Employment _____ Work Ph _____

Additional Emergency Contacts:

Name _____	Relationship _____	Ph _____
Name _____	Relationship _____	Ph _____
Name _____	Relationship _____	Ph _____
Name _____	Relationship _____	Ph _____

DR. _____ **Group** _____ **Ph** _____

Does this Student have? (Circle Yes or No)

Yes No Asthma	Yes No Diabetes	Yes No Emotional problems
Yes No Kidney problems	Yes No Bowel problems	Yes No Bone/Joint problems
Yes No Vision problems	Yes No Hearing problems	Yes No Speech problems
Yes No Glasses	Yes No Contacts	Yes No Hearing problems

Yes No Any other assistive devices? Describe _____

Yes No Seizure Disorder – Type and Frequency _____

Yes No Heart problem – Any limitations? _____

Yes No Attention Deficit Hyperactivity Disorder (ADHD) Yes No Attention Deficit Disorder(ADD)

Yes No Known allergy to bee sting? Check symptoms: difficulty breathing _____ swollen eyes _____
unusual swelling _____ nausea/vomiting _____

Yes No Known **food allergies**? Food _____ Reaction _____

Yes No Known **medication allergies**? Medication _____ Reaction _____

Yes No Any other allergies? List and give symptoms _____

List any other health conditions _____

Medications taken on a regular basis _____

Other children from this family attending school at Liberty this year are:

Name _____ Grade _____ Name _____ Grade _____

Name _____ Grade _____ Name _____ Grade _____

Name _____ Grade _____ Name _____ Grade _____

I give my permission to the school and the nurse to obtain, disclose, and discuss health information from my child's physician when indicated.

Date _____ **Parent/Guardian Signature** _____