

LINCOLN R-2 SCHOOL EMERGENCY SHEET

If any of this information changes, please notify the school immediately.

Student's Name _____ Birthdate _____ Grade _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Physical Address (if different from mailing address): _____

Phone No. _____ Student's Cell No (if applicable) _____

Parent e-mail Address: _____

Father's (or Guardian's) Name _____ Father's Cell No. _____

Father's (or Guardian's) Employment & Phone No _____

Mother's (or Guardian's) Name _____ Mother's Cell No. _____

Mother's (or Guardian's) Employment & Phone No _____

Please list a relative or friend with a telephone that can be reached in an emergency. (Please be sure that person is available, knows they are the designated contact and willing to get the student if he/she is ill when you cannot be reached.)

Name _____ Relationship _____ Phone No. _____

Family Physician _____ Dentist _____

For Hospital Emergency Room Care, please send my child to _____ Hospital.
If emergency treatment is required for your child and you cannot be reached immediately, may school authorities use their own judgment in calling one of the local doctors indicated above, or, if not available, another doctor to give treatment necessary for the health and welfare of your child? In the event of a life threatening emergency, may a local ambulance be called and the student sent to the hospital as designated?

YES _____ NO _____ If no, what do parents want done? _____

Does your child have any food, medical, other allergies? Yes _____ No _____

If yes, please explain _____

Does your child take any medicine? (Example – ADD/ADHD, Diabetes) AT HOME: Yes _____ No _____

AT SCHOOL: Yes _____ No _____

If yes, please list _____

Does your child have any medical problems? Yes _____ No _____

If yes, please explain _____

If this or any other serious health problem occurs at school, what action should be taken by the school nurse or teacher?

In case of illness, please check below yes or no if the school may administer over-the-counter drugs to your child.

Yes _____ No _____ Non-aspirin pain reliever. (Tylenol)

Yes _____ No _____ Cough drops or throat lozenges.

Yes _____ No _____ Tums.

Parent Signature _____ Date: _____