

**School Health Services
Emergency & Illness Information**

****IMPORTANT: RETURN FIRST WEEK OF SCHOOL IN A SEALED ENVELOPE.**

Last Name _____

Personal Data

Student's Name _____ DOB _____ Grade _____ Teacher _____

Father's Name _____ Mother's Name _____

Home Address _____ Phone No. _____

Place of Employment

Father _____ Working Hours _____ Business Phone _____

Mother _____ Working Hours _____ Business Phone _____

NAME OF LOCAL PERSON TO CONTACT IF PARENT (S) ARE NOT AVAILABLE. (This must be completed)

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Health Information

Please list any medical problems, severe allergies, etc. which would require immediate medication or medical attention (if none, please state "none") _____

Please list the full names and birth dates of other children in the family: _____

Physician/Dentist Information

Family Doctor _____ Office Phone _____

Address _____

Family Dentist _____ Office Phone _____

Address _____

RELEASE

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers school authorities to exercise their judgement in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room.

Parent Signature _____ Date _____

Parent Signature _____ Date _____

SPECIAL NOTE: Please notify school officials immediately as to changes or modifications to any information stated.