

**WOLCOTT PUBLIC SCHOOLS HEALTH SERVICES  
EMERGENCY CONTACT  
2019-2020**

**STUDENT INFORMATION**

Name \_\_\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ Home tel. # \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**Father/Guardian Name** \_\_\_\_\_ Home tel. # \_\_\_\_\_

Address if different from above \_\_\_\_\_ Place of Employment \_\_\_\_\_

Work tel. # (w. ext.) \_\_\_\_\_ Cell tel. # \_\_\_\_\_ Email \_\_\_\_\_

**Mother/Guardian Name** \_\_\_\_\_ Home tel. # \_\_\_\_\_

Address if different from above \_\_\_\_\_ Place of Employment \_\_\_\_\_

Work tel. # (w. ext.) \_\_\_\_\_ Cell tel. # \_\_\_\_\_ Email \_\_\_\_\_

Student lives with: Both parents  Mother  Father  Other  Please specify \_\_\_\_\_

Parents or guardians listed above have permission to pick up the child, unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting noncustodial parents or others from contact with the child. Provide the principal with a copy of the order.

**LOCAL CONTACT INFORMATION**

Those designated below are authorized to pick up my child from school in an emergency:

**Local contact's name** \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home tel. # \_\_\_\_\_ Work tel. # (w. ext.) \_\_\_\_\_ Cell tel. # \_\_\_\_\_

**Local contact's name** \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home tel. # \_\_\_\_\_ Work tel. # (w. ext.) \_\_\_\_\_ Cell tel. # \_\_\_\_\_

**Local contact's name** \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home tel. # \_\_\_\_\_ Work tel. # (w. ext.) \_\_\_\_\_ Cell tel. # \_\_\_\_\_

**MEDICAL/PHYSICIAN INFORMATION**

**Does your child have medical insurance?** Yes  No

List student's known food, drug, insect allergies or medical conditions \_\_\_\_\_

\_\_\_\_\_ EpiPen prescribed? Yes  No

If EpiPen is prescribed, student must have a doctor authorization form on file in the school nurse's office.

\*Medical information will be shared with appropriate personnel.

**Food allergy info will be shared with food service dept.**

Does your child have asthma? Yes  No  What medication is your child taking for asthma? \_\_\_\_\_

**Doctor's name** \_\_\_\_\_ Tel. # \_\_\_\_\_

Hospital preference \_\_\_\_\_

Insurance company \_\_\_\_\_

**Dentist's name** \_\_\_\_\_ Tel. # \_\_\_\_\_

In a medical emergency, we hereby authorize the school district to seek emergency medical assistance for our child if we cannot be reached. **Parent/Guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Please keep a copy of this form for your records. \*\*\*\*\*Please update your school immediately if any information changes.\*\*\*\*\*