LIST NAMES OF CHILDREN

last	first
last	first
last	first

FAMILY/STUDENT HEALTH AND EMERGENCY INFORMATION

1. PARENT/GUARDIAN _____
   ADDRESS _____ PHONE _____
   EMPLOYMENT _____ WORK PHONE _____

2. PARENT/GUARDIAN _____
   ADDRESS _____ PHONE _____
   EMPLOYMENT _____ WORK PHONE _____

PERSONS TO CONTACT IF PARENTS ARE NOT AVAILABLE:
NAME _____ RELATIONSHIP _____ PHONE _____
NAME _____ RELATIONSHIP _____ PHONE _____

In the event of an emergency (earthquake or other disaster) release my children to: *(Complete only if different from the above)*

NAME _____ RELATIONSHIP _____ PHONE _____
NAME OF FAMILY DOCTOR _____ PHONE _____
NAME OF FAMILY DENTIST _____ PHONE _____
HOSPITAL PREFERENCE _____ PHONE _____
HEALTH INSURANCE (Check)
Private/Group _____ Medicaid _____ No Health Insurance _____

THE SCHOOL IS REQUIRED TO HAVE CURRENT AND COMPLETE IMMUNIZATION RECORDS ON EACH CHILD BY THE FIRST DAY OF SCHOOL.

The school will never dispense internal medication at the request of a student. NO ASPIRIN/TYLENOL WILL BE DISPENSED. In response to parental request, the school will arrange that medicine which is clearly labeled, be stored and dispensed by a responsible adult. Often this request is a temporary one. If you wish to request this service on a regular basis, please explain: _____

The school will assist students who have minor accidents or ailments, by using ordinary external supplies such as bandages, antiseptic solution, adhesive tape, cold packs, etc. If you do not wish any of these supplies used for your child, please explain: _____

- Financial assistance is available, for those who qualify, for dental and/or eye care, shoes, & immunizations. If you would like more information on this, please contact your school principal.
- Vision and hearing screenings will be made annually.
- Scoliosis (curved spine) screening will be ordered during the fall of each school year for both boys and girls in grades 6 through 8. If you do not want your child screened, please notify the school.

AUTHORIZATION FOR SCHOOL OFFICIALS IN CASE OF EMERGENCY:

I authorize school officials to secure emergency treatment if I cannot be reached. I will assume responsibility for expenses incurred. (Parent, add your initials by each child's name on the back.)

Date _____ **Parent Signature** _____

LIST CHILDREN FROM OLDEST TO YOUNGEST

1. **Student's name** _____ _____ _____
last first middle age grade

Birthdate _____ Social Security number _____

List health conditions or disabilities _____

List medications your child is allergic to _____

Other allergies (food, seasonal, bandaids, other) _____

Medication taken routinely _____ as needed _____

Any vision/hearing problems? Yes/No (wears glasses, contacts, hearing aid)
Explain _____

Child has had a physical exam in the last two years? Yes ___ No __ Child has had a dental exam in the last year? Yes ___ No ___

Child has received an immunization or boosters in the last year? Yes ____ No ____ Type _____ Date _____

2. **Student's name** _____ _____ _____
last first middle age grade

Birthdate _____ Social Security number _____

List health conditions or disabilities _____

List medications your child is allergic to _____

Other allergies (food, seasonal, bandaids, other) _____

Medication taken routinely _____ as needed _____

Any vision/hearing problems? Yes/No (wears glasses, contacts, hearing aid)
Explain _____

Child has had a physical exam in the last two years? Yes ___ No __ Child has had a dental exam in the last year? Yes ___ No ____

Child has received an immunization or boosters in the last year? Yes ____ No ____ Type _____ Date _____

3. **Student's name** _____ _____ _____
last first middle age grade

Birthdate _____ Social Security number _____

List health conditions or disabilities _____

List medications your child is allergic to _____

Other allergies (food, seasonal, bandaids, other) _____

Medication taken routinely _____ as needed _____

Any vision/hearing problems? Yes/No (wears glasses, contacts, hearing aid)
Explain _____

Child has had a physical exam in the last two years? Yes ___ No __ Child has had a dental exam in the last year? Yes ___ No ___

Child has received an immunization or boosters in the last year? Yes ____ No ____ Type _____ Date _____