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 family: ______________________

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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 the school authorities to exercise their own 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.