

Today's	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date:	Grade:
Legal Last Name of Student:	Legal First Name:	Legal Middle Name:	
Also known as:	Also known as:		

Person(s) with Whom Student Resides: father mother guardian

EMERGENCY NUMBERS – Local person to be notified when your child is ill or injured. Only the people listed on this card will be permitted to pick up your child.

1. Name: (Father):	Home Phone #:	Cell Phone #:	Work Phone #:
2. Name (Mother):	Home Phone #:	Cell Phone #:	Work Phone #:
3. Name:	Home Phone #:	Cell Phone #:	Relationship:
4. Name:	Home Phone #:	Cell Phone #:	Relationship:
5. Name:	Home Phone #:	Cell Phone #:	Relationship:
5. Name:	Home Phone #:	Cell Phone #:	Relationship:

Out of State Family Contact's Name: _____ Relationship: _____ Phone: _____

Medical Conditions (please check all that apply):

ADD <input type="checkbox"/>	Eczema/skin condition <input type="checkbox"/>	Known hearing loss: Yes <input type="checkbox"/> No <input type="checkbox"/>
ADHD <input type="checkbox"/>	Heart Condition <input type="checkbox"/>	Wears: Hearing Aide <input type="checkbox"/> Cochlear Implant <input type="checkbox"/>
Asthma <input type="checkbox"/>	Immunosupressed <input type="checkbox"/>	Right ear <input type="checkbox"/> Left ear <input type="checkbox"/>
Bleeding Disorder <input type="checkbox"/>	Orthopedic Condition <input type="checkbox"/>	Known vision loss: Yes <input type="checkbox"/> No <input type="checkbox"/>
Bowel/Digestive concerns <input type="checkbox"/>	Seizure disorder <input type="checkbox"/>	Wears glasses/contact lenses for:
Diabetes: Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>	Urinary Concerns <input type="checkbox"/>	Close work <input type="checkbox"/> Distance only <input type="checkbox"/>

Further explanations, Conditions not listed, or other medical concerns: _____

Allergies

Allergies/Intolerances? Yes No

Specify: _____

Reaction: _____

Epi-Pen? Yes No

Medication

Does your child take daily medication at home? Yes No

Specify: _____

Is medication needed at school? Yes No **If yes, please obtain "Administration of Medication" form from the school office.**

Medical Provider

Name of student's physician: _____ Phone #: _____

Address: _____

Medical Insurance

Name of Insurance Company: _____ Name of Insured: _____ Group #: _____ Policy#: _____

This information will be distributed to all applicable personnel.

I FURTHER DECLARE, UNDER PENALTY OF PERJURY, THAT ALL THE INFORMATION GIVEN BY ME TO THE SCHOOL ON THE REQUIRED FORMS, INCLUDING THIS FORM, IS TRUE. IN CASE OF EMERGENCY OR ILLNESS AND THE SCHOOL IS UNABLE TO REACH PARENT/GUARDIAN, MY CHILD MAY BE TAKEN TO THE NEAREST EMERGENCY FACILITY FOR TREATMENT.

Signature (father/guardian):	Signature (mother/guardian):	Relationship (if other):
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For School Use Only DISASTER EMERGENCY

Release to: _____ Destination: _____ Date: _____