CHARTWELL SCHOOL

Emergency Contact Form

STUDENT INFORMATION

Child's Name: ____ ☐ Female ☐ Male

First Middle Last

Home Address: ____

Street Number and Name Apartment Number PO Box

____

City State Zip Code

Home Telephone: ______________________ Date of Birth (mm/dd/yy): ____________________

PARENT 1 INFORMATION

Parent 1 Full Name: ____

First Middle Last

Mailing Address: ____
(if different than child's)

Street Number and Name Apartment Number PO Box

____

City State Zip Code

Parent 1 Cell Phone: ______________________ Parent 1 Email: ______________________

PARENT 2 INFORMATION

Parent 2 Full Name: ____

First Middle Last

Mailing Address: ____
(if different than child's)

Street Number and Name Apartment Number PO Box

____

City State Zip Code

Parent 2 Cell Phone: ______________________ Parent 2 Email: ______________________

EMERGENCY CONTACT INFORMATION

(If the school is unable to establish contact with a parent during an emergency or illness, list relatives or friends who are able to act on your behalf)

Name #1: ______________________________ Phone: ______________________

Relationship to Child: ____

Name #2: ______________________________ Phone: ______________________

Relationship to Child: ____

PERSON AUTHORIZED TO PICK UP CHILD AT SCHOOL *(other than parents & include carpool drivers)*

Name #1: ______________________________ Phone: ______________________

Relationship to Child: ____

Name #2: ____ Phone: _________________________________

Relationship to Child: ____

PHYSICIAN INFORMATION Name: ____________________________________ Phone: ____________________

DENTIST INFORMATION Name: _____________________________________ Phone: ____________________

MEDICAL AUTHORIZATION

_______ I hereby grant Chartwell School permission to take whatever action may be necessary in supplying emergency medical services to my child. I understand that Chartwell will attempt to contact and follow the instructions of the parent/guardian, physician or other persons designated as emergency contacts. In the event that Chartwell is unable to contact any of the above persons, I hereby grant permission to Chartwell to contact and comply with the advice of an available physician, ambulance personnel or emergency room personnel. I hereby agree to be solely responsible for and will pay any expenses that may be incurred by Chartwell in making emergency medical treatment available to my child.

PRESCRIPTION MEDICATION

_______ My initials authorize Chartwell to dispense prescription medication to my child. ***Chartwell will only dispense prescription medication in the original pharmacy bottle with the child's name, dosage, doctor's name, and date on it.***

Medication #1: ________________________ Dosage: (Amount)_____________ Time: ____________

Reason: ____

Medication #2: ________________________ Dosage: (Amount)_____________ Time: ____________

Reason: ____

OVER-THE-COUNTER MEDICATION

Chartwell School may dispense the following over-the-counter medication(s) to my child as needed: *(check all that apply)*

Acetaminophen ___ Ibuprofen ___ Tums ___ Cough drops ___ Antihistamine ___ Other :________________________

Provide any additional pertinent information: ____

MEDICAL INSURANCE CARRIER INFORMATION

Name: ____ Policy Number: ___________________________

- Please explain any allergies or dietary restrictions your child has (include allergies to medications):

  ____

- Please explain any medical conditions your child has that the school should be aware of:

  ____

Parent / Guardian Signature: ____ Date: ______________________