

Northgate School District Emergency Contact Information



Student Name _____ Birthdate _____ Grade _____
Father/Guardian _____ Employer _____
Home Address _____
Phone _____ Email Address _____
Mother/Guardian _____ Employer _____
Home Address _____
Phone _____ Email Address _____
Student lives with: Both Parents ___ Mother ___ Father ___ Guardian ___

Please list brothers/sisters attending Northgate School District:

Name	Grade	Brother	Sister

Please list two other friends or relatives that can be contacted for permission to send your child home in case of minor illness when neither parent can be contacted. The Northgate School District is not responsible for transportation.

Name _____
Relationship _____ Phone _____
Name _____
Relationship _____ Phone _____

Medication Permission/Medical Authorization

My child has my permission to receive the following medications as needed during school at the discretion of the school nurse: Check Yes or No for each:

Tylenol (Acetaminophen) Yes ___ No ___
Antacid (Tums, Rolaids) Yes ___ No ___
Ibuprofen (Advil/ Motrin) Yes ___ No ___

If neither parent/guardian can be contacted in the case of serious illness or injury, I hereby authorize representatives of Northgate School District to act as my agent to secure emergency medical treatment for this child when such emergency medical treatment is deemed necessary by appropriate school representatives when my child is attending, going to, or leaving school. I hereby agree to hold the Northgate School District and its representatives harmless for exercising its judgment in authorizing such emergency hospital treatment and said representatives are specifically authorized to sign any required emergency treatment forms on my behalf. I also agree to assume responsibility for any charges incurred as a result of such treatment.

Parent Signature _____ Date _____

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Student Health History

All information given to the School Nurse is considered confidential and will only be shared with other school personnel with permission. Please sign below for permission.

I give the School Nurse permission to share any necessary information with the appropriate teachers/staff at Northgate Middle/Senior High School.

Parent Signature _____ Date _____

Check any of the following Health conditions that your child may have:

Epilepsy/Seizure disorder

Asthma Does your child need to carry an inhaler? Yes No

Diabetes Does your child need to test his/her blood sugar at school? Yes No

Allergies

Please list all drug/food allergies _____

Other conditions _____

Please list any current health problems for which your child is being treated:

Please list all medications your child is taking (at home or school):

Please list any Previous Illnesses/Injuries/Surgeries:

Family Physician _____ Phone _____