**This form is two-sided – please complete both sides.**

**Student Information – Please verify that the information is correct.** Date ______________________

Student: ______________________________ Student #: _______________

Street Address: ______________________________ Birth Date: _______________

Mailing Address: ______________________________ Gender: _______________

City, State, Zip: ______________________________ Grade: _______________

***Please attach documentation regarding unique circumstances concerning legal guardianship of the above named student.***

**Emergency Contact Information/Contact Pickup – Parents will be called first. Please list other parties in the order they should be called.**

*The individuals below have authorization to pick up my child and can be reached during school hours at the number listed.*

Name: ____________________________ Relationship: ___________________ Phone: ___________________

Name: ____________________________ Relationship: ___________________ Phone: ___________________

Name: ____________________________ Relationship: ___________________ Phone: ___________________

Name: ____________________________ Relationship: ___________________ Phone: ___________________

**Emergency & Health Information:**

***In case of serious accident or illness at school, your child will be sent to an emergency medical facility. The parent(s)/guardian(s) is/are responsible for all expenses.***

Physician's Name: __________________ Phone: ____________ Dentist __________________ Phone______________

Medical Conditions: Asthma ☐ Arthritis ☐ ADHD ☐ Bladder/Bowel control ☐

Cerebral Palsy ☐ Cystic Fibrosis ☐ Diabetes: ☐ insulin type_________ oral medication ______________

Fainting spells ☐ Headaches ☐ Head injury/concussion ☐ Date occurred _________

Hearing deficit ☐ Heart Condition ☐ High Blood Pressure ☐ Kidney Disorder ☐

Nose bleeds ☐ Orthopedic condition ☐ Psychiatric condition ☐ Seizures: ☐ type _______________

Skin disorder ☐ Sickle cell disease ☐ Spina Bifida ☐ Tourette's Syndrome ☐

Allergies: Bee sting: _______ Medications: _____________ environmental ________ other _____________

Food allergy/Dietary Restrictions: ______________________________________________________________________

Describe allergic reaction and treatment __________________________________________________________________

1. Does your child require the use of an Epi-pen? Yes No
2. Does your child require the use of inhaler? Yes No
3. Does your child require medication to be taken at school? Yes No

If you answer yes to any of the above questions, please compete the School Medication Form , signed by your physician and bring the medication to the school nurse in it's original container.

Insurance Group# ____________________________________________ Insurance ID# ________________________

May your child receive Acetaminophen (Tylenol) from the nurse at school? ☐ Yes ☐ No

***(Complete reverse side)***

## Parent/Guardian Information #1

Name: ______________________________

Relationship: father/mother guardian foster parent

Home Address: ______________________________ Legal Guardian: ☐ Yes No

City, State, Zip: ______________________________ Resides With: ☐ Yes ☐ No

Employer: ______________________________ Home Phone: ______________________

Address: ______________________________ Work Phone: ______________________

City, State, Zip: ______________________________ Cell Phone: ______________________

## Parent/Guardian Information #2

Name: ______________________________

Relationship: father/mother guardian foster parent

Home Address: ______________________________ Legal Guardian: ☐ Yes No

City, State, Zip: ______________________________ Resides With: ☐ Yes ☐ No

Employer: ______________________________ Home Phone: ______________________

Address: ______________________________ Work Phone: ______________________

City, State, Zip: ______________________________ Cell Phone: ______________________

Parent/Guardian Comments:

________________________________________________________________________

________________________________________________________________________

**Student Name**: ______________________________

Print Parent/Guardian Name (1): ______________________________

Parent/Guardian Signature (1) ______________________________ Date: ________________

Print Parent/Guardian Name (2): ______________________________

Parent/Guardian Signature (2) ______________________________ Date: ________________

***(Requires signature of all parents / guardians student resides with.)***

**(complete reverse side)**

***If any of this information changes during the school year please contact Ms. Kathy Bartolovic, School Nurse.**