SPECIAL EDUCATION DISTRICT OF LAKE COUNTY

18160 W Gages Lake Road, Gages Lake, Illinois 60030 847-548-8470 FAX 847-548-8472 VP 224-207-8476 www.sedol.us

SCHOOL EMERGENCY INFORMATION

PLEASE COMPLETE IN FULL AND RETURN TO SCHOOL ON THE FIRST DAY OF ATTENDANCE.
SEDOL WILL BE SHARING THIS INFORMATION WITH YOUR SON/DAUGHTERS TRANSPORTATION COMPANY.

Student's Name: _____ **Teacher:** _____ **ID#** _____

Address: _____ **Birthdate:** _____ **Resident District:** _____

City: _____ **State:** **Zip Code:** _____ **School:** _____

Primary/Home Phone: _____ **Program:** _____

Daycare Phone: _____ **Alert Now:** _____

Parent/Guardian: **Parent Guardian:**

Name: _____ **Name:** _____

Cell Phone: _____ **Cell Phone:** _____

Employer's Name: _____ **Employer's Name:** _____

Employer Phone: _____ **Employer Phone:** _____

Relationship to Student: _____ **Relationship to Student:** _____

E-Mail: _____ **E-Mail:** _____

IF THE SCHOOL NEEDS TO BE INFORMED OF ANY CUSTODY AGREEMENTS DUE TO DIVORCE OR OTHER ISSUES, SEND A COPY OF THE COURT DOCUMENTATION WITH THIS EMERGENCY INFORMATION FORM.

MEDICAL INFORMATION

Family Doctor: _____ Phone: _____ FAX: _____

Doctor's Address: _____ City: _____ Zip Code: _____

Seizures?: Yes ☐ No ☐ If yes, What type: _____ Date of last seizure: _____

Allergies?: Yes ☐ No ☐ If yes, What allergies: _____

Describe Reaction:

Shunt?: Yes ☐ No ☐ Location: _____ Last Revision: _____

Any surgeries in the last 12 months? Yes ☐ No ☐ If yes, please explain: _____

Any hospitalizations in the last 12 months? Yes ☐ No ☐ If yes, please explain: _____

Does your child take routine medications at home? Yes ☐ No ☐ If yes, please list: _____

What medications are given in school? _____

Comments: _____

COVID-19 VACCINATION STATUS

Individuals are considered "fully vaccinated" two weeks after completing the second dose of a two-dose COVID-19 vaccine. (e.g., Pfizer or Moderna)

My child has received both doses of a COVID-19 vaccination, and is considered fully vaccinated: ☐ YES ☐ NO

Please provide the 2 dates that vaccinations were administered: _____ & _____.

OTHER AUTHORIZED PERSONS (THREE DIFFFERENT NAMES)

PLEASE LIST A RESPONSIBLE PERSON who could pick the child up at school in case of illness. **If the parents listed above cannot be reached:**

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

PLEASE LIST RESPONSIBLE PERSON who could make a decision regarding the child in an emergency when neither parent nor physician can be reached:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

EMERGENCY ADDRESS CLOSE TO HOME where child may be dropped off if parents are not home:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

I HEREBY AUTHORIZE THE ABOVE EMERGENCY STEPS IN CASE EMERGENCY TREATMENT IS NECCESARY. I HEREBY GIVE PERMISSION FOR MY CHILD TO BE TAKEN TO THE NEAREST DOCTOR OR HOSPITAL AND I AGREE TO PAY ALL FEES IN CONNECTION WITH SUCH TREATMENT OR SERVICE.

Signature of Parent/Guardian _____ Date _____

MEDICAL INFORMATION (Cont.)

Medications - At Home:

Medication Name:	Dosage:	Time:

Medications - At School:

Medication Name:	Dosage:	Time:

GENERAL QUESTIONS - Has your student EVER experienced the following:

Seizures?	Yes ☐	No ☐	Orthopedic equipment?	Yes ☐	No ☐
Chronic or recurring treatment?	Yes ☐	No ☐	Skin Problems?	Yes ☐	No ☐
Injury requiring medical treatment?	Yes ☐	No ☐	Diabetes?	Yes ☐	No ☐
Hospitalizations?	Yes ☐	No ☐	Asthma?	Yes ☐	No ☐
Surgeries?	Yes ☐	No ☐	Diarrhea / constipation?	Yes ☐	No ☐
Shunt?	Yes ☐	No ☐	Incontinence?	Yes ☐	No ☐
Shunt Revision? (Type & Date below)	Yes ☐	No ☐	Painful / abnormal menstruation?	Yes ☐	No ☐
Frequent headaches?	Yes ☐	No ☐	Eating disorder?	Yes ☐	No ☐
Head injury?	Yes ☐	No ☐	Depression?	Yes ☐	No ☐
Unconscious?	Yes ☐	No ☐	Anxiety?	Yes ☐	No ☐
Wear glasses or contacts?	Yes ☐	No ☐	Emotional disorder?	Yes ☐	No ☐
Wear hearing aid?	Yes ☐	No ☐	Bipolar disorder?	Yes ☐	No ☐
Frequent ear infections?	Yes ☐	No ☐	Panic attacks?	Yes ☐	No ☐
Dizziness?	Yes ☐	No ☐	Psychosis?	Yes ☐	No ☐
Chest pain?	Yes ☐	No ☐	Tic disorder?	Yes ☐	No ☐
High Blood Pressure?	Yes ☐	No ☐	Autism?	Yes ☐	No ☐
Heart murmur?	Yes ☐	No ☐	Obsessive Compulsive Behaviors?	Yes ☐	No ☐
Back pain?	Yes ☐	No ☐	Other?	Yes ☐	No ☐
Problems with joints?	Yes ☐	No ☐	Other?	Yes ☐	No ☐
Atlanto-Axial instability?	Yes ☐	No ☐	Other?	Yes ☐	No ☐
Kidney disorder?	Yes ☐	No ☐	Other?	Yes ☐	No ☐

Explain ALL YES responses:

EMERGENCY MEDICAL INORMATION FOR BUS DRIVERS

STUDENT NAME: _____

NICKNAME: _____

DATE: _____

PLACE CHILD'S CURRENT PICTURE **HERE**

TYPE OF SEAT: (MARK ONE)

☐ Car Seat ☐ Seat Belt

☐ Wheelchair ☐ Booster Chair

☐ Child Safety Vest (Harness)

Lifting/Handling Precautions (if any): _____

LANGUAGE/HEARING/VISION:

Primary Language: _____

☐ Communicates/Understands Spoken Words

☐ Non-Verbal but Understands Spoken Words

☐ Hearing Impaired and/or Uses Sign Language

☐ Vision Impaired/Blind

☐ Non-Verbal, Uses Pictures

☐ Non-Verbal, Uses Gestures

☐ Watch Child's Expressions

BEHAVIORS CHILD MAY EXHIBIT:
Behaviors that the driver might encounter and need to respond to, such as kicking, crying, head banging, etc.

SUGGESTED RESPONSE TO BEHAVIORS:
What the driver can do to reduce the behavior, such as ignore, speak in calm manner, etc.

THE FOLLOWING THINGS WHICH MAY OCCUR DURING TRANSPORTATION MAY FRIGHTEN OR UPSET MY CHILD:

DRIVER SHOULD TRY TO REASSURE/CALM THE STUDENT BY:
These could include singing, whispering, changing seat assignment, etc.

DAILY CHILD CARE ARRANGEMENTS:
Name and Address of caretaker(s), please identify days, times and locations.

If your student is age 12 or older, can the student be dropped off at home without a parent being present? ☐ Yes ☐ No

PLEASE DESCRIBE ANY OTHER EMERGENCY INFORMATION BELOW:

NAME/PHONE OF DOCTOR
Who has further information about this condition: