BRADFORD ELEMENTARY SCHOOL

Part of the Oxbow Unified Union School District | A Community of Learners Empowered Through Experience

Emergency Contact Information

Student Information

Grade: __________ Name: ____

Teacher: __________________________________ Date of Birth: ________________

Contact Information for Parent/Guardians Living in the Home

Parent/Guardian Name: ___________________________
Email: _______________________________
Home phone: __________________________
Cell phone: ___________________________

Physical address: _________________________________
Mailing address: __________________________________

Employer: __________________________________
Phone: _______________________________

Parent/Guardian Name: ________________________________
Email: _______________________________
Home phone: __________________________
Cell phone: ___________________________

Physical address: ______________________________________
Mailing address: _______________________________________

Employer: __________________________________
Phone: _______________________________

Contact Information for Biological Parent (if not listed above)

Name: __________________________ Home phone: ____________________ Employer: _________________________
Email: __________________________ Cell phone: ______________________ Phone: ____________________________
Physical address: ____
Mailing address: ____

Contact Information for 2 Adults Who Are Authorized to Care for Your Child if You Cannot Be Reached

Name: ____
Relationship: ______________________
Phone: __________________________

Name: ____
Relationship: _________________________
Phone: ______________________________

Doctor

Name: ______________________________________ Phone: ____
What was the date of your child's last comprehensive annual well care visit received in their medical home? Date:___________

Type of health insurance: ☐ Dr. Dynasaur/Medicaid ☐ Private ☐ None
If none, dial 1-855-899-9600 for Vermont Health Connect or https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action

Dentist

Name: ______________________________________ Phone: ____
What was the date of your child's last dental exam received in their dental home? Date:_______________

Type of dental insurance: ☐ Dr. Dynasaur/Medicaid ☐ Private ☐ None
Please explain any dental concerns:____
Would you like assistance with scheduling a dental appointment? ☐ Yes ☐ No

Eye Doctor/Vision

Name: ______________________ Phone: ______________ Date of last exam: ____________

Does your child wear glasses: ☐ Yes ☐ No If yes, what is the reason? ______________________

STUDENT'S PRESENT HEALTH STATUS

Allergies that require an emergency response: (please explain) ______________________

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- Bee sting allergy: ☐ Yes ☐ No If yes, please explain: ______________________
- Food allergy: ☐ Yes ☐ No If yes, please explain: ______________________
- Medication allergy: ☐ Yes ☐ No If yes, please explain: ______________________

Asthma: Has a doctor, nurse, or other health professional ever said that your child has asthma?
☐ Yes ☐ No ☐ Don't know/not sure

If yes, does your child still have asthma? ☐ Yes ☐ No ☐ Don't know/not sure

Diabetes: ☐ Yes ☐ No

Immunizations received since last August: ______________________

Medications taken on a regular basis: (please explain) ______________________

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Seizures: ☐ Yes ☐ No

Would you like the School Nurse to contact you about the above information? ☐ Yes ☐ No

I authorize the School Nurse, Principal, School Counselor, Classroom Teacher or Special Education Case Manager to exchange health information with the above health care providers if needed for educational purposes or my child's well being. ☐ Yes ☐ No

In case of a serious accident or illness involving my child, when I cannot be reached: I hereby authorize the Bradford Elementary School staff to seek emergency medical care including transportation to the hospital or doctor. I hereby authorize healthcare providers and hospital to give any reasonable and customary medical and health care deemed necessary at my expense. It is understood that I will be financially responsible for all emergency care. The information on this form may be shared with school staff and emergency personnel as necessary.

Parent Signature: ______________________ Date: ______________