Red Creek Central School

Emergency & Health Information

Please return to NURSE'S OFFICE as soon as possible

Please fill out form completely (FRONT & BACK). Leave no space blank. Thank You.

Student Information:

Grade_____ Date of Birth _____

Student Name _____ Home Phone ( ) ____-_____
Last First M.I.

Address _____ Mailing if different _____
Street Town/ State Zip

All persons living in home (name, age, relationship) _____

_____

Is there a custody order in place? Yes or No (if yes a copy must be provided)

1st Parent/ Guardian contact: Okay to pick- up? Yes ___ No ___

Name _____ Relationship _____
Last First MI

Address _____ Mailing if different _____
Street Town/ State Zip

Home ( ) ____-_____ Cell ( ) ____-_____ Work ( ) ____-_____ Work Place _____

2nd Parent/ Guardian contact: Okay to pick- up? Yes ___ No ___

Name _____ Relationship _____
Last First MI

Address _____ Mailing if different _____
Street Town/ State Zip

Home ( ) ____-_____ Cell ( ) ____-_____ Work ( ) ____-_____ Work Place _____

Emergency Contact Information: (Other than parent / legal guardian)

If I am unavailable to pick-up my child and you have unsuccessfully tried to reach me, the following have permission to pick-up my child (*we will try both parents first unless you notify us differently).*

Name _____ Relationship_____ Home ( ) ____-_____

Address _____Cell ( ) ____-_____Work ( ) ____-_____

Name _____ Relationship_____ Home ( ) ____-_____

Address _____Cell ( ) ____-_____Work ( ) ____-_____

Additional names may be added on a separate sheet. You may also add or delete any emergency contacts during the school year by notifying the school in writing.

_____ Date_____

Signature of Parent / Guardian

Red Creek Central School District

Confidential Health Information

Student Name _____ Grade _____
Family Doctor Name_____ Doctor Phone _____

Emergency Medical Information- please tell us about any health condition your child is experiencing:

_____
_____
_____
_____

Bee stings/ Food allergies: Doctor/ hospital confirmed allergy? Yes ____ No____
If yes, what is your child allergic to? _____
Does your child need to take medication for this allergy? Yes ____ No____
If yes, what medication does your child take? _____
Is this medication to be kept in school? Yes ____ No____

Allergies: _____
_____

Diet Restrictions: _____
_____
_____

Medication student is taking and why: _____
_____
_____

Hospital preferred: _____

This information may be shared with any necessary staff members.