

INTER-LAKES SCHOOL DISTRICT HEALTH & EMERGENCY INFORMATION

Student's Last Name: _____ First: _____ Middle: _____
Grade: _____ Birthdate: _____ Gender: _____ HR Teacher: _____
Mailing Address: _____
Physical Address: _____

PARENTS/GUARDIANS

Parent/Guardian Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Phone: _____ Cell Phone: _____	Home Phone: _____ Cell Phone: _____
Work Phone: _____ Employer: _____	Work Phone: _____ Employer: _____
E-Mail: _____	E-Mail: _____
Lives with: _____ Can Pick Up: _____	Lives with: _____ Can Pick Up: _____
Emergency Contact: _____	Emergency Contact: _____

OTHER CUSTODIAL PARENT or NON-CUSTODIAL PARENT

Name: _____ Relationship: _____
Mailing Address: _____
Home Phone: _____ Cell Phone: _____ E-Mail: _____
Lives with: _____ Can Pick Up: _____ Emergency Contact: _____
Do you want student and/or school information to be mailed to this address? **Yes:** _____ **No:** _____

#1 EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
E-Mail: _____ Can Pick Up: _____

#2 EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____
E-Mail: _____ Can Pick Up: _____

STUDENT HEALTH INFORMATION

Does this student take medication regularly, have any specific allergies or specific medical conditions, such as:
Glasses ☐ ADD/ADHD ☐ Asthma ☐ Seizures ☐ Allergies ☐ Diabetes ☐ Other ☐

PLEASE EXPLAIN IN DETAIL: _____

Does this student take daily medication? Yes ☐ No ☐ If yes, name of medication: _____

_____ EpiPen Yes ☐ No ☐ Inhaler Yes ☐ No ☐

Physician/Phone: _____ Dentist/Phone: _____

Medical Insurance: BC/BS ☐ Healthy Kids ☐ School Insurance ☐ Other ☐ None ☐

In the event of a life threatening emergency the school will call 911 and administer oxygen if needed. In case of an accident or serious illness, I request that the school call me first. If I cannot be reached, please call the emergency contacts listed. In the event that my child suffers an anaphylactic reaction (severe allergic reaction), I give permission to the school nurse to administer EpiPen. I also allow the school nurse to share health information with other school personnel working with my child.

Signature of Parent/Guardian: _____ Date: _____

I give permission for my child to be given the following over the counter medications: Benadryl ☐ Tums ☐ Midol ☐
Tylenol (acetaminophen) ☐ Cough/Cold Elixir ☐ Motrin/Advil (ibuprofen) ☐ Topicals ☐ Cough Drops ☐

I give permission for my child to change into school clothing if necessary Yes ☐ No ☐

Signature of Parent/Guardian: _____ Date: _____

