

STUDENT: \_\_\_\_\_  Male  
Last Name First Name Counselor Grade  Female

FATHER / GUARDIAN: \_\_\_\_\_  
Name Signature Phone 1

PLACE OF EMPLOYMENT: \_\_\_\_\_  
Phone 2

E-MAIL: \_\_\_\_\_  
Phone 3

MOTHER / GUARDIAN: \_\_\_\_\_  
Name Signature Phone 1

PLACE OF EMPLOYMENT: \_\_\_\_\_  
Phone 2

E-Mail: \_\_\_\_\_  
Phone 3

**EMERGENCY INFORMATION**

In the event of illness or an emergency, and only if you are unable to pick-up your child, we will release your child only to an adult. Upon verbal confirmation from you, and proper identification from the person listed below, we will then release the student.

Name of Adult: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Name of Adult: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

If above persons are not available, you may call our family physician. You have my permission to transport my child to a hospital in case of an emergency.

If your child drives to school/walks to school, and you request the child to drive/walk home (due to illness or emergency), please sign below indicating you give permission for your son/daughter to leave school grounds. Upon verbal confirmation from you and the school nurses' medical sanction, we will release the student from the nurse's office. Please allow my child to sign-out with my permission.

- Drives to school  Walks to school  Taxi / Alternate ride

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL INFORMATION**

STUDENT DATE OF BIRTH: \_\_\_\_\_  
Month Day Year

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Eye Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Last Visit: \_\_\_\_\_

PLEASE CHECK ALLERGIES: Bees \_\_\_\_\_ Wasps \_\_\_\_\_ Yellow Jackets \_\_\_\_\_ Foods \_\_\_\_\_  
Medication \_\_\_\_\_ Plants \_\_\_\_\_ Animals \_\_\_\_\_ Other \_\_\_\_\_

Treatment for allergies: \_\_\_\_\_

Is your child on any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Time Given \_\_\_\_\_ Doctor \_\_\_\_\_

I give consent for the school nurse:

- YES NO
- to share health information with appropriate school personnel for my child.
- to contact my child's physician regarding health information as needed.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_