Revised March 2026

HERTFORD COUNTY PUBLIC SCHOOLS

Pursuit of Excellence: Unleashing Our Potential

Student Emergency Information

2026-2027

Name: ____
Last *First* *Middle*

Address: ____
Address *City/State* *Zip*

Home Phone: ____________ **Cellphone:** ____________ **Email :** ____________

Birth date: ____________ **Grade:** ______ **School:** ____________ **Teacher/Homeroom** ____________

Transportation from school: **Bus#** ____________ **Walk** ____________ **Carpool** ____________

Person responsible for picking up child ______________________________

Student lives with: ❐ **Parent(s)** ❐ **Guardian(s)**

Mother's Name: ______________________________ **Phone:** ____________

Mother's Place of Employment: ______________________________ **Phone:** ____________

Father's Name: ______________________________ **Phone:** ____________

Father's Place of Employment: ______________________________ **Phone:** ____________

Guardian's Name: ______________________________ **Phone:** ____________

Guardian's Place of Employment: ______________________________ **Phone:** ____________

List up to four contacts who may assume temporary care of your child if you cannot be reached.

1. **Name:** ____________ **Phone:** ____________ **Relation to Student:** ____________
2. **Name:** ____________ **Phone:** ____________ **Relation to Student:** ____________
3. **Name:** ____________ **Phone:** ____________ **Relation to Student:** ____________
4. **Name:** ____________ **Phone:** ____________ **Relation to Student:** ____________

Name of Siblings	School They Attend

In case of a medical emergency, injury or serious illness, school personnel will try to reach me personally. If unable to do so, I hereby authorize school personnel to take or send my child to the family physician, dentist, or the hospital. I further acknowledge, I will be responsible for the expenses of the visit.

______________________________ ____________
Parent/Guardian's Signature **Date**

Hospital: Vidant Roanoke-Chowan Hospital

Note: Hertford County Schools refers students only to Vidant Roanoke-Chowan Hospital since it is the only such facility in the county.

I give my permission to the School Health Nurse to share or receive health-related information needed to care for my child with other healthcare providers (for example: doctor, dentist, eye doctor) during the 2026-2027 school year. Yes ❐**No**

______________________________ ____________ ____________
Parent/Legal Guardian's Signature **Date** **Daytime Phone Number**

Please See Reverse Side

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Student Health Information

Check YES or NO for each of the following:

Chronic Condition	Yes	No
Attention Deficit Hyperactivity or Attention Deficit		
Allergic to:(*Please specify)* A. Food		
B. Seasonal		
C. Other		
Anorexia/Bulimia		
Arthritis		
Asthma		
Bladder Issues		
Bleeding Disorder		
Cancer/Leukemia		
Cerebral Palsy		
Cystic Fibrosis		
Diabetes		
Down's Syndrome		
Epilepsy		
Epistaxis (Nosebleeds)		

Check YES or NO for each of the following:

Chronic Condition	Yes	No
Feeding Problems		
Genetic Disorders		
Hearing Deficit		
Heart Issues		
Hepatitis		
High Blood Pressure		
Kidney Disease		
Menstrual Problems		
Mental Health Disorder		
Migraines		
Multiple Sclerosis		
Muscular Dystrophy		
Obesity		
Orthopedic Problems		
Seizures		
Sickle Cell Anemia		
Stomach Problems		
Tuberculosis		
Vision Deficit		

Other conditions: *(Be specific)*	Comments:

Has your child had a head injury/concussion in the past year?	*Yes*	*No*
If yes, is the child still under medical care/supervision?	*Yes*	*No*

Medication Information	Yes	No	Describe
Does your child take medication(s) daily?			
Does your child need medication at school? *If your child needs medication at school, you must request a medication authorization form.			
I need a medication authorization form.			

***Please note: If your child needs to take *ANY* medication (prescription or over the counter) at school, an *Authorization for Medication During School Hours* form must be completed and on file with the nurse. This form can be obtained from the school office and must be submitted each school year. All medication must be brought to school by an adult, in a pharmacy labelled container or original package/box and not sent with the student or bus driver.**