MORRIS HILLS REGIONAL DISTRICT **2026-2027**

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: _____