MEDICAL EMERGENCY VERIFICATION FORM 2015-2016

STUDENT INFORMATION	
Student Name:	Bus #:
Residential Address:	DOB:
City, State, Zip:	Gender:
Mailing Address:	YOG:
City, State, Zip:	ID:
Preferred Connect Ed Contact # (Home or Cell):	

PARENT / GUARDIAN INFORMATION*	
Parent/Guardian #1 EMAIL ADDRESS:	
Name:	Relationship to student:
Residential Address:	
City, State, Zip:	
Mailing Address:	
City, State, Zip:	
Lives with student: ☐ Yes ☐ No	Receives Mail: ☐ Yes ☐ No
Legal guardian: ☐ Yes ☐ No	Work Place:
Cell Phone #:	Work Phone #:

^ Mother, Father, Grandmother, Grandfather, Aunt, Uncle, etc.; Foster Parent; Social Worker

Parent/Guardian #2	
Name:	Relationship to student:
Residential Address:	
City, State, Zip:	
Mailing Address:	
City, State, Zip:	
Lives with student: ☐ Yes ☐ No	Receives Mail: ☐ Yes ☐ No
Legal guardian: ☐ Yes ☐ No	Work Place:
Cell Phone #:	Work Phone #:

^ Mother, Father, Stepmother, Stepfather, Grandmother, Grandfather, Aunt, Uncle, etc.; Foster Parent; Social Worker

Parent/Guardian #3 (if needed)	
Name:	Relationship to student:
Residential Address:	
City, State, Zip:	
Mailing Address:	
City, State, Zip:	
Lives with student: ☐ Yes ☐ No	Receives Mail: ☐ Yes ☐ No
Legal guardian: ☐ Yes ☐ No	Work Place:
Cell Phone #:	Work Phone #:

PLEASE COMPLETE BOTH SIDES

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EMERGENCY CONTACTS

Please list two emergency contacts who are not already listed on this form and who will assume temporary care of your child if you cannot be reached. This means that they may take your child home.

1.	Name:	
	Phone #:	Relationship to child:
2.	Name:	
	Phone #:	Relationship to child:

EMERGENCY POWER OF ATTORNEY

In the event of an accident or sudden or unexpected illness of my child, if I cannot be contacted, I authorize the school staff to call the physician named below and to follow his/her instructions. Should the named physician not be available, I further authorize, in my place and in my stead, the school to seek services of any qualified physician and to transport my child to the physician's office or hospital for treatment including x-rays, laboratory tests or whatever medical or surgical procedures are necessary on an emergency basis. I hereby authorize such physician to render such medical and surgical treatment and I agree to pay the customary fees or charges for such treatment.

Signature of parents or guardians below:	Date:
Mother:	Father:

I give permission to release medical information to staff as necessary. All medical information is considered confidential.

Signature:	Date:

Does your child have Health Insurance?	☐ Yes	☐ No
Health Insurance Company:		
Policy #:		

Primary Care Physician Full Name:	Office Phone #:
Dentist Full Name:	Office Phone #:
Orthodontist Full Name:	Office Phone #:
Hospital Preference:	Phone #:

Health Concerns: (Allergies, medical conditions, etc.)		
Does your child wear glasses/contact lenses?	☐ Yes	☐ No
Does your child have a hearing problem?	☐ Yes	☐ No

CUSTODY ISSUES*:
To ensure proper parental access to student records, copies of restraining orders or custodial agreements generated in the event of parental separation, divorce or loss of custody (temporary or permanent) must be provided to the Guidance Department.
(Please explain below)

PLEASE COMPLETE BOTH SIDES