

East Central Community Schools

Start Date_____

Grade_____

Student Emergency Health Information 2011-12

Legal Name: _____
Last First M.I. Date of Birth Birth Place

Gender: M___F___ Ethnicity: Caucasian___ African Amer.___ Am Indian.___ Asian___ Hispanic___

Address: _____
Street P.O. Box# City State Zip

Phone Number: _____ Unlisted: Yes___ No___ Social Security #: _____

Did your child attend pre-school? Yes / No

Health Information Update: Please list any health conditions such as heart disease, diabetes, epilepsy, allergies to foods or medications, ADHD, eye or ear problems, surgery, or any chronic conditions:

Doctor/City: _____ Phone: _____

Hospital Preference: _____

In the past year has your child seen a: Dentist: Yes / No Date Seen _____

Eye doctor: Yes / No Date Seen _____ Doctor: Yes / No Date Seen _____

Glasses: Yes___NO___ Contact Lenses: Yes___No___ Hearing Aids: Yes___No___

Is your child on medication: Yes / No (Med. name) _____

WHERE WILL THEY NEED TO TAKE THE MEDICATION: HOME_____ SCHOOL_____

If answer was SCHOOL to above question, you must fill out MEDICATION ADMINISTRATION FORM.

IF BOTH CUSTODIAL PARENTS RESIDE WITH STUDENT, DO NOT DUPLICATE INFORMATION, FILL OUT WORK INFORMATION ONLY:

Female Parent/Guardian: _____
Custody: Yes/No Living with child: Yes/No
Street: _____
City: _____ St: _____ Zip: _____
Email: _____
Place of Employment: _____
Work #: _____
Cell #: _____

Male Parent/Guardian: _____
Custody: Yes/No Living with child: Yes/No
Street: _____
City: _____ St: _____ Zip: _____
Email: _____
Place of Employment: _____
Work #: _____
Cell #: _____

Do your children have health insurance? Yes / No

Insurance Company Name: _____

Do you need information on Free or Low-Cost Health Insurance for children: Yes / No

PLEASE FILL BOTH SIDES OF THIS FORM OUT COMPLETELY, SIGN REVERSE SIDE

over

If your student is transferring from another school system please give name/address of previous school:

School:_____

Address:_____

Please sign and date here if you have open-enrolled this student to another school district and now wish to rescind such enrollment.

Signature_____ Date_____

Please give us the names of **2 other** people that we may contact in an emergency:

NAME/RELATIONSHIP_____

ADDRESS_____

HOME PHONE NUMBER_____

CELL NUMBER_____

NAME/RELATIONSHIP_____

ADDRESS_____

HOME PHONE NUMBER_____

CELL NUMBER_____

I, the undersigned, do hereby authorize the officials of East Central School District to contact directly the person named on this form, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of the said children.

In the event the physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the said child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

My child has permission to participate in all field trips while attending this school: YES NO

Signature of Parent/Guardian_____ Date_____

School staff may take this form to school events – to be used in an emergency to contact parents/guardians or others if necessary.