

Student _____ Date of Birth _____ Grade _____

Address _____ Home Phone (____) _____

In accordance with the Missing Children’s Act, the school needs a phone number where a parent or guardian can be reached during the school hours. We need the parent’s first and last name, phone number with area code and extension (if necessary).

Mother _____ Home _____ Cell _____ Work _____

Father _____ Home _____ Cell _____ Work _____

Email address: _____

Emergency Medical Contacts – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents can not be reached.

In the event reasonable attempts to contact me (name) _____ at (phone #) _____ or the other parent (name) _____ at (phone #) _____ have been unsuccessful:

Additional Emergency Contacts – Please list two relatives/neighbors who are willing to assume responsibility for your child if you can not be reached.

Name _____ Address _____

Phone #1 _____ Phone #2 _____

Name _____ Address _____

Phone #1 _____ Phone #2 _____

If parents are divorced, which parent has legal custody/ _____

May non-custodial parent be contacted? Yes _____ No _____ Non-custodial parent’s name _____

If custodial parent is remarried, may the school contact the step-parent in regard to school related matters? Yes _____ No _____

Step-parent Name _____

TO GRANT CONSENT

This must be completed

I hereby give my consent for:

- 1. The administration of any treatment deemed necessary by:

(Preferred Physician) Dr. _____ Phone # _____

(Preferred Dentist) Dr. _____ Phone # _____

or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and,

- 2. The transfer of my child to _____ (preferred hospital) or any hospital that is reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed. Facts concerning the child’s medical history including allergies, medications being taken and physical impairments to which a physician should be alerted:

PARENT SIGNATURE _____ DATE _____

“Significant health concern information may be shared confidentially with appropriate school personnel to ensure the student’s health and safety.”