SAINT MICHAEL SCHOOL
EMERGENCY INFORMATION FORM (2011 – 2012)

PLEASE PRINT INFORMATION Grade/Teacher_____Primary Language:_____

Student's Name:_____ Sex: Female ___Male_____
Last **First**

Address:_____ Date of Birth:_____
Street City State Zip

Mother's Name: _____ Employer: _____Occupation_____
Mother's Home #_____Cell # _____ Work #_____

Father's Name: _____ Employer:_____ Occupation_____
Father's Home #_____ Cell #_____ Work # _____

E-Mail Address: Mom,_____Dad_____
Guardian Name: _____Phone #_____E-Mail:_____

Ethnicity: White____ Hispanic____ Asian _____ Vietnamese_____ Cambodian _____ African American_____Other_____

IN CASE OF EMERGENCY, List 2 adults (other than parent/guardian) who will assume immediate care of your child or pick up your child at school in the event of illness or emergency:

Name:_____Relationship _____Phone Number_____

Name:_____Relationship _____Phone Number_____

In case of medical emergency, does the school have your permission to take your child to the nearest hospital?

Yes__No__ If yes, Name of Hospital: _____Physician's Name: _____ Phone#_____

Medical Insurance Carrier and Policy Number_____

Does your child have health insurance: Yes__or No__. If your child has NO health insurance, Massachusetts has health insurance plans that will provide uninsured children with affordable health care (restrictions may apply). Please contact the city nurse for more information.

Circle all current or active health conditions that apply to your child:
ADD ADHD Anxiety Asthma Autism/PDD Cerebral Palsy Depression Diabetes Gastric Disorder
Heart Condition Lactose Intolerance Migraines MS Spinal Bifida Seizure Disorder Other: (please list) _____

List medication and dosage taken by your child on a regular basis or as needed:_____

Vision Problems (specify) ____Glasses ___Contacts ____Blackboard ____Reading _____Preferential seating
Hearing Problems (specify) ___Left ___Right Hearing aides: ___Left ___Right (Tubes in ear ___L ___R) ___Preferential seating
Height_____ Weight_____

Is your child allergic to any **medication**? _____ What medication_____
Allergies:(Please list)_____
Is your child prescribed an **Epi pen** for treatment of the allergy listed above? ____YES ___NO

Does your child require any special nursing procedures during the school day? (7:50-2:00) _____
If so, what is the procedure? _____How often is it performed during school hours? _____

I herby authorize you to contact my child's physician if I cannot be reached and such a call is considered necessary. I also give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel as needed to meet my child's health and safety needs.
Yes____ No____

Please record how your child is transported to and from school: _____ WALK (has permission to walk home)
_____ Gets picked up & dropped off _____Extended Day Program

Parent/Guardian signature_____ Date: _____