

Family and Emergency Information – 2010-2011

Name _____ D.O.B. _____ Grade _____
(Last) (First) (MI)

Address _____
(No.) (Street) (City/Town) (Zip Code)

Phone _____ E-Mail _____ Fax _____

SS # (optional) _____ Race (optional - provides info for yearly statistical reports) _____

Student lives with _____ Guardian _____ (if applicable)

Father's Name _____
(First) (Last)

Mother's Name _____
(First) (Last)

Religion _____

Religion _____

Address _____

Address _____

Phone _____

Phone _____

Father's Occupation _____

Mother's Occupation _____

Title or Position _____

Title or Position _____

Name of Company _____

Name of Company _____

Business Address _____

Business Address _____

Business Phone _____

Business Phone _____

Cell Phone _____

Cell Phone _____

E-Mail _____

E-Mail _____

Other siblings presently attending C-C:

1. _____ Grade _____ 2. _____ Grade _____

List two neighbors/relatives who could assume temporary care of your child should you be unavailable.

Name _____ Relation _____

Address _____ Phone _____

Name _____ Relation _____

Address _____ Phone _____

Are there any individuals who are restricted by court order from picking up your son/daughter? _____

Name of individual _____ Relationship to child _____

Please provide a copy of the documentation.

OFFICIAL PARENT SIGNATURE _____

Health Information

26

Health Update for _____ Grade _____

Please fill in the following information, which is important in the case of serious illness or emergency. At any point during the school year that there is a change in a student's health history or changes in medication, please notify the school nurse.

Health Insurance Company _____ Policy Number _____

Does your child have a doctor diagnosed allergy to the environment? food? medication? insects? If yes, please describe. _____

If doctor diagnosed allergies exist, please describe the specific allergic reaction:

Vision problems _____ Glasses _____ Contacts _____

Hearing problems _____

Illness, injuries, or surgery since last year? _____ If yes, please describe.

List medications taken on a regular basis (at home or at school), dosage, and time taken and the reason the medication is taken. *(If this changes during the school year, please contact the health office to update the information.)*

Medication	Dose	Time Taken	Reason for taking medication
------------	------	------------	------------------------------

Please refer to medication administration policy in the student handbook. Medication forms are needed for any medication given to students at school.

Does your child have any doctor diagnosed chronic health problem(s)? Please list below.

In case of accident or serious illness, and I am unable to be contacted, the school will call the physician named below and follow his instructions. If it is impossible to contact the physician, the school will make whatever arrangements are deemed necessary.

Name of Physician _____ Phone _____

Address _____

I give permission for the school nurse to share pertinent medical information with the school staff.

Parent/Guardian Signature _____ Date _____