

Health and Emergency Information

THIS FORM IS DUE IN THE OFFICE ON THE FIRST DAY OF ATTENDANCE

Please note: This information will be shared with staff.

Student's Name: _____ **Date of Birth:** ____/____/____

To safely treat your child in an emergency, please list any pertinent medical issues such as allergies, reactions to drugs, or any other conditions:

Please list any dietary restrictions or habits:

Parent/Guardian's Name: _____

Address: _____

Employer: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Parent/Guardian's Name: _____

Address: _____

Employer: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Physician's Name: _____ **Phone Number:** _____

Insurance Company: _____

Group Number: _____ Policy Number: _____

Dentist's Name: _____ Phone Number: _____

In a medical emergency, the following people may authorize medical care for the child named above:

Name: _____

Address: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Please fill out both sides of this document.

Name: _____

Address: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Name: _____

Address: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Permission to pick up my child(ren): In addition to the above, the following are allowed to pick up my child(ren):

Name: _____

Address: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Name: _____

Address: _____

Email address: _____

Home phone: _____ Work phone: _____ Cell Phone: _____ Text? Y/N

Emergency Treatment Authorization

I request that my child(ren) receive first aid whenever it is deemed necessary. In case of emergency illness or accident involving my child(ren), Carbondale New School is authorized to proceed with emergency procedures. I give my permission for authorized school personnel to transport my child(ren) ***if I cannot be reached*** and to seek other emergency care if our family physician cannot be reached.

Parent/Guardian's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____