**Emergency Information and Medical Record**

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| STUDENT INFORMATION |
| Name  | **Sex**  \_\_\_\_\_\_ Male \_\_\_\_\_\_ Female |
| Address  |
| Age | **Birth date**  |
| Father/Stepfather/Guardian’s name  |
| Address (if different from student) |
| Home phone | **Cell Phone**  |
| Work Phone | **E-Mail**   |
| Mother/Stepmother/Guardian’s name |
| Address (if different from student) |
| Home phone | **Cell Phone**  |
| Work Phone | **E-Mail**   |
| Address (if different from student) |
| EMERGENCY INFORMATION |
| Doctor’s Name | **Phone Number** |
| Hospital Name/Address |

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| Hospital Preference (for emergencies) |
| 1. Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? No\_\_\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_, as follows: |
| 2. Does your child have any of the following conditions? Please answer yes or no.\_\_\_\_\_\_\_\_\_\_\_ Allergies \_\_\_\_\_\_\_\_\_\_\_ Frequent sore throats/colds \_\_\_\_\_\_\_\_\_\_\_ Ear Aches\_\_\_\_\_\_\_\_\_\_\_ Asthma \_\_\_\_\_\_\_\_\_\_\_ Speech, Visual, Hearing \_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_ Epilepsy/Seizures \_\_\_\_\_\_\_\_\_\_\_ Other:If yes answered to any above, please provide additional information: |
| Date of last tetanus booster | **Medications being taken** |
| Please provide additional information or special instructions that will help the person caring for your child. |

**Please list the names of people to call if student is injured or becomes ill at school. List in the order they are to be called.**

* Persons authorized to pick up the child or to notify in case of emergency. Include name, telephone number, and relation to student.

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| 1.Name  | Phone Number | Relation to Student |
| 2. Name  | **Phone Number** | **Relation to Student** |
| 3. Name  | **Phone Number** | **Relation to Student** |
| 4. Name  | **Phone Number** | **Relation to Student** |

**Signature of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**