Intermediate District 287

RESPONSIVE. INNOVATIVE. SOLUTIONS.

Student Emergency and Health Information 2014-2015

ID #:_____School #:_____
School Name:_____
Site Name:_____
Address:_____
_____

Please fill in **ALL** information requested below. If extra space is needed, please use back side of form. Thank You.

Student:_____ Student's E-mail:_____

Home Phone: (_____) _____-_____ Date of Birth:_____/_____/_____ Gender:_____

Parent or Guardian:_____ Relationship to Student:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Student Lives With: ☐

E-mail:_____ Place of Employment:_____

Parent or Guardian:_____ Relationship to Student:_____

Address:_____ City:_____ State:____ Zip:_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ Student Lives With: ☐

E-mail:_____ Place of Employment:_____

Group Home Name:_____ Group Home Contact:_____

Address:_____ City:_____ State:____ Zip:_____

Cell Phone: (_____) _____-_____ Other Phone: (_____) _____-_____ Contact's E-mail:_____

Immunizations within the last year: (Type and mo/day/yr) _____

Health Conditions:_____

Does the student have a history of: Seizures? Yes ☐ No ☐ Asthma ? Yes ☐ No ☐ Diabetes? Yes ☐ No ☐

Medications and Dosages:_____

List Any Allergies: _____

IN CASE OF A STUDENT EMERGENCY (Two contacts who would care for this student in case a parent or guardian cannot be reached) Please circle to indicate home (H), work (W) or cell (C) for contact phone numbers.

Contact:_____ Address:_____

Phone: (H W C) (_____) _____-_____ Phone: (H W C) (_____) _____-_____ Relationship to Student:_____

Contact:_____ Address:_____

Phone: (H W C) (_____) _____-_____ Phone: (H W C) (_____) _____-_____ Relationship to Student:_____

Is the student on Medical Assistance? Yes ☐ No ☐ MA #:_____

Insurance Provider:_____ Phone: (_____) _____-_____

Primary Health Care Provider:_____ Phone: (_____) _____-_____

Mental Health Care Provider/Psychiatrist _____ Phone: (_____) _____-_____

Neurologist: _____ Phone: (_____) _____-_____

Hospital Preference:_____

County Social Worker:_____ E-mail:_____ Phone: (_____) _____-_____

County Case Manager:_____ E-mail:_____ Phone: (_____) _____-_____

Our procedure will be to contact the parent at home or at work. You will be asked to pick up the student and provide proper care. If we cannot reach you, we will call the friend, relative, or neighbor that you have listed above and ask them to care for your student. In extreme emergency, an ambulance will be called and your student will be taken to the nearest hospital. The cost of this will be covered by the student's parent or guardian.

Parent or Guardian Signature:_____ Date:_____/_____/_____