The Hallen School

In case of emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on both sides of this form carefully and accurately. <u>Please Use INK and PRINT clearly and legibly.</u>

<u>EMERGENCY CONTACT FORM</u>

Today's Date _______________

STUDENT:____ **Sex:** M F
Last Name First Middle

____
Home Address City Zip

____**Lives with (Circle below)**
Mailing Address (If different from above) Both Parents/ Mother/Father/Legal Guardian

MOTHER/GUARDIAN:____ **Phone:** ____________________
Last Name First Home/Work/Cell

____**Phone:** ____________________
Home Address (If different from above) City Zip Home/Work/Cell

FATHER/GUARDIAN:____**Phone**:____________________
Home/Work/Cell

____**Phone**:____________________
Home Address (If different from above) City Zip Home/Work/Cell

Parent/Guardian Email (Optional):____

<u>AUTHORIZED CONTACTS</u> Please list the names of relatives/neighbors/Friends that we may release your child/ or contact if you cannot be reached. ***NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS, OR ADULTS LISTED ON THIS PAPER***.

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation, or emergency that may occur while students are in school.

Name	Relationship	Daytime Phone	Cellular Phone

I declare that the information on this form is true and correct. I will notify the school immediately of any changes to be made to this form.

<u>Parent/Guardian</u>

Signature:________________________________Date___________________Relationship___________________

PLEASE CONTINUE TO PAGE 2

The Hallen School

ANNUAL UPDATE/MEDICAL CONSENT

STUDENT____

Last Name **First Name** **Middle**

Health Insurance Information: (Please circle one) No Health Insurance Family Health Insurance

Health Plan/Group Name____ Policy No.__________________________

Date of last well child exam______________________Date of last dental checkup___________________________

Physician/Health Care Provider_____________________________________PhoneNo.________________________

Dentist____ Phone No._____________________________________

Does the student have any condition or health issue that may affect participation in any physical activity?
YES or NO **If yes Please explain**:____

MEDICAL CONDITIONS: (Please circle all that apply)

Allergies:
Food/Environmental **Insects** **Medications** (*Please list allergies all below)*

____

Severe Allergies Requiring: Epi-Pen / Benadryl

Diabetes YES/NO Insulin Dependent Insulin Pump Used

Asthma YES/NO Uses Inhaler On daily medication Asthma Action Plan

Seizures YES/NO Febrile Other (please explain) ____

If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. An Authorization of medication" form must be on file. Please list all medications below.

Medication	*Dose*	*Route*	*Time taken*

Vision/Hearing Problems: NONE Glasses Contacts / For reading All of the time
Does your child wear a Hearing aid? Yes or NO / Location:____
Has your child been identified as having bleeding tendencies? ____
Has your child been diagnosed hyperactive by your physician?____
Behavior Problems: ____
Movement Limitations: ____

EMERGENCY TREATMENT AUTHORIZATION

In the event of an emergency, I request the school contact me, if they are not able to reach me and emergency care is considered necessary, I give permission to the school to seek emergency medical care, including transportation to and care at the closest emergency facilities, and I assume financial responsibility for such. I give permission to the school nurse/counselor/principal to contact my child's medical or dental care providers for the purpose of sharing, or requesting pertinent information to my child's health and care, or treatment received.

____ **Date**____________________
Signature of Parent or Guardian