THE HALLEN SCHOOL

97 Centre Avenue
New Rochelle, NY 10801
(914) 636-6600, Fax: (914) 613-6990

EMERGENCY INFORMATION SHEET

A parent/legal guardian must complete this form. PLEASE PRINT.

Student's Name: ____

Gender: _______________ Date of Birth: ____ /______ / _________ NYC ID#: ____________________________

Parent/ Guardian: ____

Home/Mailing Address: ____

City, State, Zip Code____

Home#: (____) ______ - _________ Work#: (____) _____ - _________, ext. _____ Cell#: (____) ______ - _________

Student lives with: (A) ____ Relationship: _________________________

Home/Mailing Address: ____

City, State, Zip Code____

Home#: (____) ______ - _________ Work#: (____) _____ - _________, ext. _____ Cell#: (____) ______ - _________

E-mail Address: ____

Student lives with: (B) ____ Relationship: _________________________

Home/Mailing Address: ____

City, State, Zip Code____

Home#: (____) ______ - _________ Work#: (____) _____ - _________, ext. _____ Cell#: (____) ______ - _________

E-mail Address: ____

PARENT/GUARDIAN & EMERGENCY CONTACT PROCEDURE

In case of an emergency, please contact (number the preferred contact method – 1, 2, 3) as indicated:

1. Name: ____ Relationship: _________________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

2. Name: ____ Relationship: _________________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

3. Name: ____ Relationship: _________________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

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AUTHORIZED CONTACTS **

Student Name: ____ D.O.B.: ________________

Please list the names of persons that we may release your child to and/or contact if you cannot be reached. No student will be released to anyone other than the parent/guardian or adults listed below:

1. Name: ______________________________________ Relationship: ___________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

2. Name: ______________________________________ Relationship: ___________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

3. Name: ______________________________________ Relationship: ___________________

   Home: (____) _____ - _________ Work: (___) _____ - _________, ext. ____ Cell#: (____) _____ - ________

** If applicable, NEVER release my child to: ____

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

CONSENT FOR MEDICAL AND EMERGENCY TREATMENT

In the event of an emergency, I request the school contact me. If not able to reach me and emergency care is considered necessary, I authorize the school to contact and follow the instructions of:

Name of Family Physician or Pediatrician: ____

Address: ____

City, State, Zip Code: ____

Telephone#: (_______) ________ - ______________ Notes: ___________________________________

I give my permission for the school nurse to administer First Aid as needed. In the event that emergency contacts cannot be reached promptly, I hereby give the school authority to obtain the necessary Emergency Medical Treatment for my child with the understanding that the family will be notified as soon as possible. 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 to contact my child's medical or dental providers for the purpose of sharing or requesting pertinent information related to my child's health, care, or treatment received.

____

Parent/Legal Guardian: Print Name Signature

Date: ______/______/__________ Comments: ____

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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#: ______________________

Date of last well child exam: _____________________ Date of last dental checkup: ______________________

Physician/Health Care Provider: ______________________________ Phone#: _______________________

Dentist: ____ Phone#: _______________________

Does the student have any condition or health issue that may affect participation in any physical activity?

Circle: YES or NO If yes, please explain: ____

MEDICAL CONDITIONS: (Circle all that apply)

Allergies:
Food Environmental Insects

Severe Allergies:
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, it must be sent to 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 Contacts Glasses: for reading all the time

Hearing aid: NO YES – Location: ____

Bleeding tendencies: ____

Has your child been diagnosed hyperactive by your physician? NO YES: __________________________

Behavior Problems: ____

Movement Limitations: ____