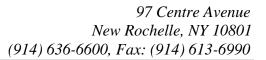


## **EMERGENCY INFORMATION SHEET**

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

Student's Name:					
Gender:	Date of Birth:/_	/	N	YC ID#:	
Parent/ Guardian:					
Home/Mailing Address: _					
City, State, Zip Code					
Home#: (	Work#: (	)	, ext	Cell#: ()	
Student lives with: (A)			R	elationship:	
Home/Mailing Address: _					
City, State, Zip Code					
Home#: (	Work#: (	)	, ext	Cell#: ()	
E-mail Address:					
Student lives with: (B)			I	Relationship:	
Home/Mailing Address: _					
City, State, Zip Code					
Home#: ()	Work#: (	)	, ext	Cell#: ()	
E-mail Address:					
	RENT/GUARDIAN & emergency, please contact			CT PROCEDURE t method – 1, 2, 3) as indicated:	
1. Name:			R	elationship:	
Home: ()	Work: (	)	, ext	Cell#: ()	
2. Name:			R	elationship:	
Home: ()	Work: (	_)	ext	Cell#: ()	
3. Name:			R	elationship:	
Home: ( ) -	Work: (	) -	. evt	Cell#: ( ) -	





## **AUTHORIZED CONTACTS \*\***

Student Name:		D.O.B.:			
Please list the names of persons that w released to anyone other than the paren			cannot be reached. No student will be		
1. Name:		Relationship:			
Home: ()	Work: ()	, ext	Cell#: ()		
2. Name:		Relati	onship:		
Home: ()	Work: ()	, ext	Cell#: ()		
3. Name:		Relati	onship:		
Home: ()	Work: ()	, ext	Cell#: ()		
In the event of an emergency, I reques necessary, I authorize the school to co	ntact and follow the instruc	oot able to reach me a tions of:	and emergency care is considered		
Name of Family Physician or Pediatric	cian:				
Address:					
City, State, Zip Code:		<del></del>			
Telephone#: (	No	otes:			
I give my permission for the school nu reached promptly, I hereby give the sc the understanding that the family will medical care, including transportation for such. I give permission to the school requesting pertinent information related	hool authority to obtain the be notified as soon as possi a to and care, at the closest ol to contact my child's med	necessary Emergeno ble. I give permission emergency facilities; lical or dental provid	ry Medical Treatment for my child with a to the school to seek emergency and I assume financial responsibility ders for the purpose of sharing or		
Parent/Legal Guardian: Print Name		Signa	ture		
Date:/	Comments:				



## ANNUAL UPDATE/MEDICAL CONSENT

STUDENT								
	Last Name			First Name			Middle	
Health Insurance Information: (Please circle one)			No Hea	Health Insurance Family Health Insurance			ince	
Health Plan/Gro	oup Name:				Policy#:			
Date of last wel	l child exam:			Date of last den	tal checkup:			
Physician/Healt	h Care Provider: _				Phone#:			
Dentist:			Phone#:					
Does the studen	t have any conditi	on or health issue	that may a	ffect participatio	n in any physic	cal activity	?	
Circle: YES or l	NO If yes,	please explain:		<del></del>				
MEDICAL CO	ONDITIONS: (Cir	cle all that apply)						
Allergies: Food	llergies:				rgies: Benac	dryl		
Diabetes	YES/NO	Insulin Depende	ent	Insulin Pump U	sed			
Asthma	YES/NO	Uses Inhaler		On daily medication		Asthr	na Action Plan	
Seizures	YES/NO	Febrile		Other (please ex	aplain):			
		at school, it must b					current date and the	
MEDICATION		DOSE		ROU	JTE	7	TIME TAKEN	
Vision/Hearing	Problems:	None	Contacts	Glasses	s: for	reading	all the time	
Hearing aid:	NO	YES – Location	:					
Bleeding tender	ncies:							
Has your child b	been diagnosed hy	peractive by your	physician?	NO	YES:			
Behavior Proble	ems:							
Movement Limi	itations:							