



**LANCASTER
MENNONITE
SCHOOL**

Campus:

- Kraybill
- Lancaster
- Locust Grove
- New Danville

It is important to have this information on file in the event of a medical emergency or other emergency involving your child. Although some of this information is in our database or other school records, a hard copy of this sheet will be available for easy access in emergencies when the computers may not be operational.

Emergency Information

Student Name: _____ **Grade:** _____ **Gender:** _____

Street Address: _____

City: _____ **State:** ____ **Zip Code:** _____

Mother's Name: _____ **Home phone:** _____

Mother's Employer: _____ **Work phone:** _____

Cell phone: _____

Father's Name: _____ **Home phone:** _____

Father's Employer: _____ **Work phone:** _____

Cell phone: _____

Guardian's Name: _____ **Home phone:** _____

Guardian's Employer: _____ **Work phone:** _____

Cell phone: _____

Student lives with : Both parents Mother Father Guardian Foster Family
 Mother & Stepfather Father & Stepmother Other: _____

Custody information on file with the school? Yes No
 (please check one if separated or divorced)

Emergency Contacts (other than parents)

Name: _____ **Relationship:** _____

Phone: _____ **Alternative phone:** _____

Name: _____ **Relationship:** _____

Phone: _____ **Alternative phone:** _____

Name: _____ **Relationship:** _____

Phone: _____ **Alternative phone:** _____

Physician's Name: _____ **Physician phone:** _____

Dentist's Name: _____ **Dentists' phone:** _____

In the event of an emergency, the school will attempt to contact the parents, guardians and emergency contact persons. If the school is unable to reach them, the undersigned authorizes the school to contact the physician listed above and follow his/her instructions. If the physician cannot be reached, the undersigned authorizes the school to make whatever arrangements it deems necessary for the health and safety of the child.

Parent/Guardian signature: _____ **Date:** _____



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Special Health Concerns

Student Name: _____ Grade: _____ Gender: _____

Asthma? Yes No Emergency inhaler needed at school? Yes No

Seizures? Yes No If yes, type? _____
Date of last seizure: _____

Diabetes? Yes No If yes, Type 1 Type 2
Diet restrictions: _____

Cardiac condition? Yes No If yes, gym restrictions? Yes No

Severe allergies? Yes No peanuts tree nuts milk shellfish
 other allergies: _____

Drug allergies? Yes No If yes, please list: _____

Other medical conditions? Yes No If yes, please list: _____

Emotional problems? Yes No _____

Serious illness, injury hospitalization or operation? Yes No
If yes, date: _____ Describe: _____

Still under treatment? Yes No

Restrictions on physical activity? Yes No
Describe: _____

Medications (taken at home or in school)

Name: _____ Dose: _____ Times: _____ Reason: _____

Name: _____ Dose: _____ Times: _____ Reason: _____

Name: _____ Dose: _____ Times: _____ Reason: _____

Name: _____ Dose: _____ Times: _____ Reason: _____

Name: _____ Dose: _____ Times: _____ Reason: _____

glasses contact lenses hearing aids ear tubes

other devices: _____

The school nurse may prepare a confidential list of students with significant health concerns of which teachers and staff should be aware to protect the health and well-being of those students. By signing below, you allow the nurse to share any health information she/he deems appropriate for persons caring for your child to know.

The undersigned consents to the release of immunization records, physical and/or dental exams from the student's physician's office. Yes No

Parent/Guardian signature: _____ Date: _____