



**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:** _____

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

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

I consent to emergency medical treatment for the Student when the situation does not reasonably allow time to contact the persons named above. When the situation does allow, I understand the School will make reasonable efforts to contact the Student's parents/guardians and emergency contact persons listed above. If the school is unable readily to reach them, I authorize the School to contact the physician listed above and to follow the physician's instructions, and for the administration of medical care accordingly. If the physician cannot readily be reached, I authorize and consent to the administration of medical care deemed advisable for the Student by another physician or physicians. This authority includes but is not necessarily limited to any medical and surgical procedures and admission to a medical facility. Intending to be legally bound, I agree to be responsible for the cost of any medical care provided, and release and indemnify the School and its agents for the good faith exercise of this authority.

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

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



**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.

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

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: _____

Insurance information

Insurance Company: _____

Member ID #: _____ Agreement #: _____

Group #: _____ Telephone #: _____

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: _____