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: ____________________

Special Health Concerns

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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: _____________________