

*****FOR THE SAFETY OF YOUR CHILD, PLEASE NOTE THAT ALL EMERGENCY CONTACTS WILL BE REQUIRED TO SHOW PHOTO ID UPON PICKING UP STUDENTS.**

Name: _____ Grade: _____ Date of Birth: ____/____/____ Sex: _____

Address: _____ Primary Phone: _____

Student lives with: _____ Parent/Guardian email address: _____

Mother/Female Guardian: _____ Cell: _____

Place of Employment for Above: _____ Work Phone: _____

Father/Male Guardian: _____ Cell: _____

Place of Employment for Above: _____ Work Phone: _____

Please provide us with the names of neighbors, friends or relatives who the school may call to pick up the student if the parent/guardian is unable to be reached. **Those listed below will only have permission if called by the school. Complete the PERMISSION TO PICK-UP FORM for "any time" dismissals by non-guardians.**

Name: _____ Phone: _____ Cell: _____

Name: _____ Phone: _____ Cell: _____

Name: _____ Phone: _____ Cell: _____

In the event none of the above contacts listed are able to be reached during an emergency, students may be transported to the nearest emergency facility (usually Nanticoke Memorial Hospital).

Primary Care Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Eye Doctor: _____ Phone: _____

Insurance Information: Health/Accident Ins: _____ School Policy: _____ Commercial Ins: _____ Medicaid: _____ Other: _____

Name of Other Ins: _____ Policy #: _____ Group#: _____

I give the nurse my permission to give my child non-prescription medications (Tylenol, Motrin, throat lozenges, antacids, etc.). These will be administered according to package directions unless parents have made other arrangements with the school nurse.

Yes **No**

▶▶▶▶ Parent/Guardian Signature: _____

Please answer all questions below (check all that apply):

Asthma: _____ Diabetes: _____ Headaches: _____ Epilepsy/Seizures: _____ Heart Murmur: _____ Heart Disease: _____

Kidney Problems: _____ Bleeding Problems: _____ Premature Birth: _____ Orthopedic (bone) Problems: _____ Other: _____

Explain any problems checked above: _____

List any ALLERGIES (medicine, food, insect bites) and describe reactions: _____

Wears: Glasses: _____ Contacts: _____ Date of last eye exam: _____ Hearing Problems: _____ Aid Needed: _____

Does the student take any medications regularly for any illness?: _____

(Medication must be received in the original container and permission must be given to nurse to administer.)

Any other health problems: _____

Date of last physical exam: _____ Doctor: _____ Phone: _____

Has the student had any of the following since last school year: Dental Problems: _____ Surgery: _____

Emotional Upsets: _____ Illness: _____ Other: _____