

Student Information

Last Name		First Name		Middle Name		Sex		Date of Birth	/	/	
Social Security Number		Place of Birth City, State and Zip code									
Address											
Phone Number		Medicaid Number		Email Address							
Student Lives with:	Both Parents	Father	Mother	Guardian	Stepmother	Stepfather					
Racial/Ethnic Origin:	White	Hispanic	Black	Asian	Other: _____						

Parent/Guardian Information

Name (First, Middle, Last)	Address	Phone Number		Place of Employment	Work Phone Number
Father:		H:	C:		
Mother: Maiden Name:		H:	C:		
Step Parent/Guardian:		H:	C:		

If parents are divorced/separated:

*Who has legal (court appointed) custody?	
*If joint custody, who has residential custody?	
*Is there a restraining order?	Yes No Against Whom?

School Alert System for Delays and Closures

_____ Phone Number

*A copy of these documents MUST be provided to the school.

List **TWO LOCAL** adults (other than parents/guardians) who will assume temporary care of your child in case of emergency or who they can be released to:

Name		Relationship		Address		Phone	
Name		Relationship		Address		Phone	

Siblings

Name	Age	Grade	School Attending

Your student may accompany their class on school organized field trips?	Yes	No
Student's picture and video may be used for educational, promotional, or other program purposes?	Yes	No
May participate in swim program?	Yes	No
Does your student know how to swim?	Yes	No
May be included in class roster (Name, parent(s) name, date of birth, and phone number)?	Yes	No

Signature of Parent/Guardian

Date

For Office Use Only

For Teacher Use Only

Sent to EMIS		Entry Date		Withdrawal Date		Date of Last MFE		School District of Residence	
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Emergency Medical Authorization Form

Student Name: _____

Address: _____

Phone Number: _____ Cell Phone Number: _____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mothers Name		Phone Number	
Father's Name		Phone Number	
Other's Name		Phone Number	

Name of Relative or Childcare Provider:

Name		Relationship	
Address		Phone Number	

Part I or II Must be Completed

Part I- To Grant Consent

I hereby give consent for the following medical providers and local hospital to be called:

Doctor		Phone Number	
Dentist		Phone Number	
Medial Specialist		Phone Number	
Local Hospital		Phone Number	

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted to:

Signature of Parent/Guardian _____ Date _____

Address _____

Part II- Refusal to Consent

I DO NOT give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the school authorities to take the following action:

Signature of Parent/Guardian _____ Date _____

Address _____