EAST CENTRAL I.S.D. #2580 EMERGENCY/HEALTH INFORMATION

For your child's safety and optimal learning experience, it is very important for us to be informed. Please provide the following information:

STUDENT'S NAME_____ **GRADE**_____

Persons to contact when parents cannot be reached:

Name:_____ Relationship_____ Phone_____

Name:_____ Relationship_____ Phone_____

List any and all persons who have your permission to remove your child from school:

_____

_____

State any custody arrangement/restrictions. **Court documents must be provided to be enforced.**

_____

Primary Contact:_____ Phone Number_____
(Who the student lives with)

Physician_____ Phone Number_____

Allergies (to what?)_____ Does the student have an epipen?_____

Asthma_____ Will inhaler be used at school?_____

Bowel or bladder problems_____ Please describe_____

How is the problem handled?_____

Dietary restrictions?_____

Other medical conditions? Please describe:_____

Medications (List all medications the student takes either daily or occasionally):

Medication Name	Purpose	Dosage	How often taken

_____

_____

If you have any other concerns, please contact the School Nurse.

***School District Policy states that any student taking medication during the school day must have a consent form completed and on file in the Health Office. The forms may be obtained from the Health Office OR initial below.**

I, the undersigned parent/guardian, give my consent for the above named child to be released to me or my spouse or to the friend/relative I have so designated and/or to be taken by ambulance to the nearest hospital in case of emergency.
I understand that East Central #2580 does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school. I understand that I may voluntarily purchase a student accident insurance plan.
I further acknowledge that I am financially responsible for medical, dental, ambulance, or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury.

Acetaminophen (aspirin substitute) permission, to be given at the nurse's discretion
Please initial one: _____PERMITTED _____NOT PERMITTED

Signature of Parent/Guardian_____ **Date:**_____