DEPARTMENT OF EDUCATION
EMERGENCY INFORMATION & HEALTH FORM
SY: 20 20 - 20 21

Student:_____ **School:** _____
Last First Middle Initial

Date of Birth: ____/ ___ / ____ **Male or Female** **Ethnicity:**_____ **Grade:** _____ **Room:** _____
Month Day Year ***(circle one)***

The information provided below will be used to update demographics on PowerSchool.

Father/Guardian:	**Mother**/Guardian:
Mailing Address:	Mailing Address:
Home Address	Home Address
Place of work:	Place of work:
Home Phone: Work:	Home Phone: Work:
Cell:	Cell:
Email:	Email:

Mode of Transportation: ☐ **Bus Rider** ☐ **Car Rider** ☐ **Walker**

It is required to provide an alternate contact name and number of an adult who can pick your child up from school if you cannot be contacted. All adults will be required to show photo identification when picking up your child. Students will be released ONLY to those listed below.

	Name	Relationship to Child	Home Phone	Work Phone	Cell Phone
1					
2					
3					
4					

In the event of a food borne illness, DOE/DPHSS are authorized to obtain stool/vomit samples from the child in the interest of Public Health. ☐ Yes ☐ No

I give permission for the ambulance to transport my child to: ☐ GMH ☐ Naval Hospital
☐ GRMC in a medical emergency. Insurance: _____

In case of an Emergency, DOE Reserves the Right to release contact information to your child's bus driver or the Superintendent of Operations, Department of Public Works. _____ **(Parent/Guardian Initial)**

My child is able to participate in a regular PE class and physical activities: ☐ **YES** ☐ **NO** if **"NO"** a Health Care Provider's note is required.

_____ _____
Parent/Guardian Print & Signature Date

Basic Health Data

To be filled out by Parent/Guardian to effectively meet the health needs of your child at school.

Yes	No	Complete Checklist below regarding your Child
		Rheumatic Fever
		Diabetes
		Heart Disease
		Skin Problems ☐ Eczema Other:
		Seizures Date of Last seizure:
		Hearing Problem Hearing Aid: ☐ Yes ☐ No
		Vision Problem ☐ Glasses or ☐ Contact Lenses
		Asthma ☐ Inhaler ☐ Nebulizer Date of Last asthma attack:
		Allergy to: ☐ Food ☐ Drugs ☐ Other, specify:
		Allergy to: ☐ Bee Sting ☐ Insect Type of reaction:
		Epipen ☐ Yes ☐ No
		Current Medication(s): Reason:
		Other Serious Illness or Injury:
		Other Behavioral or Mental Health Concerns:

(Please Draw a Map to your Residence)

List the names of all your children who are attending this school (include Head Start) from the oldest to the youngest.

	Child's Name	Grade	Room
1			
2			
3			
4			