**STUDENT EMERGENCY CONSENT FORM**

 **STUDENT INFORMATION**

Last First Middle

Birthdate Male Female Teacher

Address

City State ZIP

Primary Language/Dialect \_\_\_\_\_\_\_ Primary Phone

**PARENT/GUARDIAN CONTACT INFORMATION**

Relationship to child**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship to child**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name Name

Address Address

Home# Cell# Home# Cell#

Work# Work#

Employer \_ Employer

Email: Email:

 **PEOPLE AUTHORIZED TO PICK UP CHILD (In addition to parents listed above)**

**\*\*\*Please note: we will not release your child to anyone unless they are listed below\*\*\***

1.Name Relation to child Phone#

2.Name Relation to child Phone#

3.Name Relation to child Phone#

4.Name Relation to child Phone#

5.Name Relation to child Phone#

6.Name Relation to child Phone#

7.Name Relation to child Phone#

8.Name Relation to child Phone#

**ALERT INFORMATION (DO NOT RELEASE TO):**

Name Relationship

Name Relationship

Note: Copy of Divorce Decree and custodial forms are required (on file) should one or both parents/guardians no longer have parental responsibility.

**STUDENT LIVES WITH: Guardianship\***

Both Parents Mother Only Father Only Mother & Stepfather Father & Stepmother

Other If other, what is relationship to child?

\*If you marked anything other than “Both Parents”, please indicate any other important custody information below:

Who is Legal Guardian and/or has Legal Custody?

Are there custody papers? No Yes If yes, papers must be provided. Is this a Foster child? No Yes

**BIRTH INFORMATION**

Date of Birth: (Month) / (Day) **/** (Year)

Place of Birth: City State County

Born Outside of U.S.? No Yes I94 Number

**MEDICAL ALERT INFORMATION / HISTORY / ALLERGIES**

Restrictions? (i.e. Asthma, seizures, allergies, food restrictions) No Yes If yes, please give brief description below. Any questions please call the school nurse at 317-789-3941.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our School Nurse program is staffed by nurses from Community Health Network and will provide limited services to all students, including but not limited to - **screening for signs of illness, first aid/emergency care, referral to health providers in the** **community, nutrition services, health education,** **health screenings and immunization information**. This is a School clinic and all records are maintained by the School. **There is no charge to you for the services received.** Your written permission is required, in advance, if your child has a prescription or over the counter medicine, or requires management of chronic health conditions or any health needs with a physician order while in school.In an emergency situation, to prevent death or serious injury, the School Nurse and School staff will act to prevent such injury or death and stabilize the situation.

Signature of Parent or Guardian

Family Doctor Phone Hospital Preference

**SIBLINGS ATTENDING THIS SCHOOL OR OTHER PERRY TOWNSHIP SCHOOLS:**

Name Attends Grade

Name Attends Grade

Name Attends Grade

Name Attends Grade

Name Attends Grade

Name Attends Grade

Name Attends Grade