

2011-2012 CMCS
**ELEMENTARY STUDENT
 EMERGENCY INFORMATION**

For
Office
Use

- ALLERGIES
- ASTHMA

STUDENT LAST NAME		FIRST NAME	
HOME PHONE ()			GRADE
HOME ADDRESS		CITY	STATE ZIP
SEX	BIRTH DATE		TEACHER'S NAME
NAME OF PERSON(S) WITH WHOM CHILD LIVES/RELATIONSHIP		E-MAIL ADDRESS	
LEGAL MOTHER'S NAME		ADDRESS (IF DIFFERENT THAN CHILD'S)	
HOME # ()		WORK # ()	CELL # ()
EMPLOYER'S ADDRESS			
LEGAL FATHER'S NAME		ADDRESS (IF DIFFERENT THAN CHILD'S)	
HOME # ()		WORK # ()	CELL # ()
EMPLOYER'S ADDRESS			

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

PLEASE COMPLETE THE INFORMATION BELOW FOR PERSONS, OTHER THAN A PARENT, WHOM YOU AUTHORIZE TO PICKUP YOUR CHILD FROM SCHOOL. IF YOUR CHILD BECOMES ILL AT SCHOOL, AND WE ARE UNABLE TO CONTACT YOU, WE WILL CONTACT THE INDIVIDUALS YOU HAVE LISTED BELOW, IN THE ORDER LISTED. STUDENTS WILL NOT BE RELEASED TO INDIVIDUALS WHO ARE NOT LISTED ON THIS FORM.

NAME	RELATIONSHIP	PHONE #	CELL #
1.		()	()
2.		()	()
3.		()	()
4.		()	()

LIST INDIVIDUALS TO WHOM YOUR CHILD **MAY NOT** BE RELEASED UNDER LEGAL CUSTODY PROVISIONS
 (LEGAL DOCUMENTS MUST BE ON FILE IN THE SCHOOL OFFICE).

1.	2.	3.
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I AUTHORIZE CMCS TO DISPENSE THE FOLLOWING MEDICATION(S)	TYLENOL		MOTRIN		TUMS		COUGH DROPS		BENADRYL	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

ALL PRESCRIPTION MEDICATIONS REQUIRE A DOCTOR'S NOTE AND PARENT CONSENT FORM AND MUST BE DISPENSED THROUGH THE SCHOOL OFFICE. IF A PHYSICIAN NEEDS TO BE CONSULTED AND NEITHER PARENT/GUARDIAN CAN BE REACHED, YOUR SIGNATURE BELOW AUTHORIZES CMCS TO TAKE YOUR CHILD TO A LOCAL PHYSICIAN OR CONTACT THE PHYSICIAN THAT YOU HAVE LISTED, TO RENDER NECESSARY TREATMENT (AT YOUR EXPENSE). IN THE EVENT OF AN EMERGENCY, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL AND CMCS WILL BE HELD HARMLESS IN ALL DECISIONS.

NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN	HOSPITAL PREFERENCE	TYPE OF INSURANCE/POLICY #
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PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOUR CHILD

NO KNOWN PROBLEMS	VISION PROBLEMS - IF SO, DOES CHILD WEAR CONTACTS OR GLASSES?
ALLERGY - POLLEN/DUST/HAY FEVER	HEARING LOSS - IS SO, WHICH EAR?
ASTHMA - NO MEDICATION REQUIRED	ADD/ADHD - IF SO, IS MEDICATION TAKEN?
ASTHMA - REQUIRES MEDICATION	MIGRAINES - IS MEDICATION TAKEN?
BLOOD DISORDER	DIABETIC - IF SO, DID YOU PROVIDE SCHOOL WITH DIABETIC KIT?
CANCER/LEUKEMIA	ALLERGIC TO BEE STING
CEREBRAL PALSY	ALLERGIC TO THE FOLLOWING FOOD(S)
HEMOPHILIA	EPILEPSY/SEIZURES
SPEECH PROBLEM	ALLERGIC TO THE FOLLOWING MEDICATION(S)

NAME OF SIBLINGS THAT ATTEND CMCS		
1)	2)	3)

MISCELLANEOUS INFORMATION

BY SIGNING THIS CARD, I AGREE TO HOLD CMCS AND ITS EMPLOYEES HARMLESS FROM ALL LIABILITY OR CLAIMS WHICH MIGHT ARISE OUT OF THESE ARRANGEMENTS. PLEASE NOTIFY THE SCHOOL OFFICE WHENEVER ANY OF THIS INFORMATION CHANGES.

PARENT SIGNATURE	DATE
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