2011-2012 CMCS

SECONDARY STUDENT EMERGENCY INFORMATION

☐ ALLERGIES

☐ ASTHMA

For Office Use

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 # ( )	
ACTIVE MILITARY	YES NO	IF YES, MILITARY I.D. #	
LEGAL FATHER'S NAME		ADDRESS (IF DIFFERENT THAN CHILD'S)	
HOME # ( )	WORK # ( )	CELL # ( )	
ACTIVE MILITARY	YES NO	IF YES, MILITARY I.D. #	

ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY

PLEASE COMPLETE THE INFORMATION BELOW FOR PERSONS, OTHER THAN A PARENT, WHOM YOU AUTHORIZE TO PICK UP 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.

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 #*

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 FORM, 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

Copy: Health Aide and Teacher

11/10/09