



# Emergency Information 2012-2013

Grade \_\_\_\_\_

Teacher \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ D.O.B \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
\_\_\_\_\_

**Parents are:** \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated

**Mother's Name:** \_\_\_\_\_ **Father's Name:** \_\_\_\_\_

Cellular: \_\_\_\_\_ Cellular: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

Relation to Child: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

**Pediatrician:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Family Dentist:** \_\_\_\_\_ Phone: \_\_\_\_\_

**Hospital Preference:** \_\_\_\_\_

Primary Health Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

Secondary Health Insurance: \_\_\_\_\_ Policy # \_\_\_\_\_

**HEALTH HISTORY** - Check if your child has had any of the following conditions/diseases in the past.

Measles     Heart Defect/Disease     Convulsions     Frequent Ear Infections  
 Diabetes     Bleeding/Clotting Disorders     Hypertension     Chicken Pox     Asthma

**ALLERGIES** - Check all that apply.

Penicillin     Insect Stings     Poison Ivy     Hay Fever  
 Food Allergies (Please list all foods)

\_\_\_\_ Other (Please describe)

## **MEDICAL INFORMATION**

Operations or serious injuries (dates): \_\_\_\_\_

Chronic or recurring illness or medical condition: \_\_\_\_\_

Dietary Restrictions: \_\_\_\_\_

**\*IMMUNIZATION RECORD - Every new student and every child in K3, K4, and K5 must submit a current Florida Dept. of Health form #680 & 3040.**

**RELEASE:** This statement must be signed. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed school activities except as noted. In the event the parents or emergency contact cannot be reached in an emergency, I hereby give permission to the physician selected by the Principal and/or RN on staff to secure and administer treatment, including hospitalization, for the person named above. I further give permission to medical personnel selected by the Principal and/or RN on staff to order X-rays, routine tests, or treatment, to release any records necessary for insurance purposes, and to provide necessary transportation. The completed forms may be photocopied for field trips.

Parent's Signature \_\_\_\_\_

Date: \_\_\_\_\_