HERITAGE CHRISTIAN SCHOOLS EMERGENCY INFORMATION/RELEASE FORM 11-12

Please fill out one form ***per child*** *- please print .* ***This form must be returned by the first day of school (Sept. 7th).***

STUDENT NAME _____ ❑ Male ❑ Female SS# _____
Last Name First Name MI
BIRTHDATE ___/___/___ GRADE _____ HOMEROOM TEACHER _____

RESIDING ADDRESS _____ STUDENT 'S CELL # (IF APPLICABLE) _____

CITY _____ ST ZIP _____ HOME PHONE _____

IMPORTANT: TRANSPORTATION (if riding bus, please list route & bus number (i.e. Milw., # ?) _____

Student resides with:

- ❑ Both Parents ❑ Full-time ❑ Part-time _____
- ❑ Mother ❑ Father How often? _____
- ❑ Mother & step-Father ❑Full-time ❑ Part-time _____
- ❑ Father & step-Mother ❑ Full-time ❑ Part-time _____
- ❑ Other _____ ❑ Full-time ❑ Part-time _____

SPECIAL HEALTH CONCERNS/PRECAUTIONS (Asthma, Diabetes, Seizures, etc): _____

Mother/Guardian's Name: _____ Home Number _____

Employer: _____ Title: _____ Email: _____

Work Number: _____ Cell/Pager Number: _____

Father/Guardian's Name: _____ Home Number _____

Employer: _____ Title: _____ Email: _____

Work Number: _____ Cell Pager Number: _____

In the event of an illness or an emergency, who else may we contact if those listed above are not available:

Name _____ Relationship _____ Home phone _____

Work phone _____ Cell phone _____ Pager _____

_____

List any instructions/restrictions: _____

_____

ALLERGIES

Allergy _____ Reaction _____ Treatment _____

Allergy _____ Reaction _____ Treatment _____

MEDICATIONS _____ **FOR?** _____

Will these need to be taken while at school? _____ If so, the medication must be kept in the school office and taken in the presence of a school authority. Students may not have any medication (including Tylenol/Advil, etc.) on their person or in their locker/book bag while at school.

NAME OF DOCTOR _____ **Phone:** _____

Insurance: _____ **ID/Policy #:** _____

I hereby give permission for the above named child to receive/use as needed any of the following non-prescription medications that I have indicated below (✓), during the school day. I understand that my child is not allergic to any of the following checked medications and that a school representative will be administering them if needed. I will notify the school when any change in this permission is necessary. This permission is valid for the 2011-2012 school year only.

- ❑ Tylenol _____
- ❑ Advil/ Ibuprofen _____
- ❑ Benedryl / Allergy pills _____
- ❑ Antacid tablets (i.e. Tums, etc). _____
- ❑ Cough Drops _____
- ❑ Visine/Contact lens solution _____
- ❑ Neosporin _____
- ❑ Calamine Lotion _____
- ❑ Antiseptic spray _____

Parent/Guardian Signature _____ **Date** _____

Name Last First

Continued from Emergency Release Form

STUDENT NAME ______________________________ GRADE/CLASSROOM ______________

Date	Time In	Time Out	Temp	SYMPTOMS	ACTION	RESULT/COMMENTS	Initials