SCHOOL EMERGENCY INFORMATION

PLEASE COMPLETE IN FULL AND RETURN TO SCHOOL ON FIRST DAY OF ATTENDANCE

SEDOL WILL BE SHARING THIS INFORMATION WITH YOUR SON/DAUGHTER'S TRANSPORTATION COMPANY

Student's Name: _____ **Teacher:** _____ **ID#:** _____

Address: _____ **Birthdate:** _____ **Resident District:** _____

City: _____ **State:** _____ **Zip-Code:** _____ **School:** _____

Primary/Home Phone: _____ **Program:** _____

Daycare Phone: _____

Parent/Guardian:	**Parent/Guardian:**
Name:	Name:
Cell Phone:	Cell Phone:
Employer's Name:	Employer's Name:
Business Phone:	Business Phone:
Relationship to Student:	Relationship to Student:
E-Mail:	E-Mail:

IF THE SCHOOL NEEDS TO BE INFORMED OF ANY CUSTODY AGREEMENTS DUE TO DIVORCE OR OTHER ISSUES, SEND A COPY OF THE COURT DOCUMENTATION WITH THIS EMERGENCY INFORMATION FORM.

Medical Information

Family Doctor: _____ Doctor's Phone: _____ Fax: _____

Doctor's Address: _____ City: _____ Zip: _____

Seizures: Yes__ No__ If yes, What type: _____ Date of last seizure: _____

Allergies: Yes__ No__ If yes, What allergies: _____

Describe Reaction: _____

Shunt: Yes__ No__ Location: _____ Last Revision: _____

Any surgeries in the last 12 months: Yes__ No__ If yes, please explain: _____

Any hospitalizations in the last 12 months: Yes__ No__ If yes, please explain: _____

Does your child take routine medications at home: Yes__ No__ If yes, please list: _____

What medications are given in school? _____

Comments: _____

Other Authorized Persons (Three Different Names)

PLEASE LIST A RESPONSIBLE PERSON who could pick the child up at school in case of illness **<u>if the parents listed above cannot be reached</u>**:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

PLEASE LIST RESPONSIBLE PERSONS who could make a decision regarding the child in an emergency when neither parent nor pycician can be reached:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

EMERGENCY ADDRESS CLOSE TO HOME where child may be dropped off if parents are not home:

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

I HEREBY AUTHORIZE THE ABOVE EMERGENCY STEPS IN CASE EMERGENCY TREATMENT IS NECESSARY, I HEREBY GIVE PERMISSION FOR MY CHILD TO BE TAKEN TO THE NEAREST DOCTOR OR HOSPITAL AND I AGREE TO PAY ALL FEES IN CONNECTION WITH SUCH TREATMENT OR SERVICE

_____ _____

(Signature of Parent/Guardian) (Date)

EMERGENCY MEDICAL INFORMATION FOR BUS DRIVERS

STUDENT NAME: _____

NICKNAME: _____

DATE: _____

PLACE CHILD'S CURRENT PICTURE **HERE**

TYPE OF SEAT: (MARK ONE)

- ☐ Car Seat
- ☐ Seat Belt
- ☐ Wheelchair
- ☐ Booster Chair
- ☐ Child Safety Vest (Harness)

Lifting/Handling Precautions (if any): _____

_____

LANGUAGE/HEARING/VISION:

Primary Language: _____

- ☐ Communicates/Understands Spoken Word
- ☐ Non-Verbal But Understands Spoken Word
- ☐ Hearing Impaired and/or Uses Sign Language
- ☐ Vision Impaired/Blind
- ☐ Non-Verbal, Uses Pictures
- ☐ Non-Verbal, Uses Gestures
- ☐ Watch Child's Expressions

BEHAVIORS CHILD MAY EXHIBIT:
Behaviors that the driver might encounter and need to respond to, such as kicking, crying, head banging, etc.

_____

SUGGESTED RESPONSE TO BEHAVIORS:
What the driver can do to reduce the behavior, such as ignore, speak in calm manner, etc.

_____

THE FOLLOWING THINGS WHICH MAY OCCUR DURING TRANSPORTATION MAY FRIGHTEN OR UPSET MY CHILD:

_____

DRIVER SHOULD TRY TO REASSURE/CALM THE STUDENT BY:
These could include singing, whispering, changing seat assignment, etc.

_____

DAILY CHILD CARE ARRANGEMENTS:
Name and Address of caretaker(s), please identify days, times and locations.

_____

If your student is age 12 or older, can the student be dropped off at home without a parent being present? ☐ YES ☐ NO

PLEASE DESCRIBE ANY OTHER EMERGENCY INFORMATION BELOW:

_____

NAME/PHONE OF DOCTOR:
Who has further information about this condition

_____