

# 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:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip-Code:** \_\_\_\_\_  
**Primary/Home Phone:** \_\_\_\_\_  
**Daycare Phone:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_  
Name: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

**Teacher:** \_\_\_\_\_ **ID#:** \_\_\_\_\_  
**Birthdate:** \_\_\_\_\_ **Resident District:** \_\_\_\_\_  
**School:** \_\_\_\_\_  
**Program:** \_\_\_\_\_  
**Alert Now:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_  
Name: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Employer's Name: \_\_\_\_\_  
Business Phone: \_\_\_\_\_  
Relationship to Student: \_\_\_\_\_  
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 **if the parents listed above cannot be reached:**

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 physician 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)

**Medical Information (Cont.)**

**Medications - At Home:**

Medication Name:	Dosage:	Time:

**Medications - At School:**

Medication Name:	Dosage:	Time:

**General Questions - Has your student EVER experienced the following:**

Seizures?	Yes__ No__	Orthopedic equipment?	Yes__ No__
Chronic or recurring illness?	Yes__ No__	Skin Problems?	Yes__ No__
Injury requiring medical treatment?	Yes__ No__	Diabetes?	Yes__ No__
Hospitalizations?	Yes__ No__	Asthma?	Yes__ No__
Surgeries?	Yes__ No__	Diarrhea / constipation?	Yes__ No__
Shunt?	Yes__ No__	Incontinence?	Yes__ No__
Shunt Revision? (Type & Date below)	Yes__ No__	Painful / abnormal menstruation?	Yes__ No__
Frequent Headaches?	Yes__ No__	Eating disorder?	Yes__ No__
Head Injury?	Yes__ No__	Depression?	Yes__ No__
Unconscious?	Yes__ No__	Anxiety?	Yes__ No__
Wear glasses or contacts?	Yes__ No__	Emotional Disorder?	Yes__ No__
Wear hearing aid?	Yes__ No__	Bipolar Disorder?	Yes__ No__
Frequent ear infections?	Yes__ No__	Panic Attacks?	Yes__ No__
Dizziness?	Yes__ No__	Psychosis?	Yes__ No__
Chest Pain?	Yes__ No__	Tic Disorder?	Yes__ No__
High Blood Pressure?	Yes__ No__	Autism?	Yes__ No__
Heart Murmur?	Yes__ No__	Obsessive Compulsive Behaviors?	Yes__ No__
Back Pain?	Yes__ No__	Other	Yes__ No__
Problems with joints?	Yes__ No__	Other	Yes__ No__
Atlanto-Axial Instability?	Yes__ No__	Other	Yes__ No__
Kidney Disorder?	Yes__ No__	Other	Yes__ No__

**Explain ALL YES responses:**

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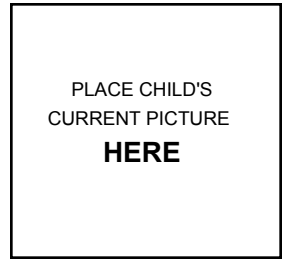
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**EMERGENCY MEDICAL INFORMATION FOR BUS DRIVERS**

STUDENT NAME: \_\_\_\_\_

NICKNAME: \_\_\_\_\_

DATE: \_\_\_\_\_



**TYPE OF SEAT: (MARK ONE)**

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

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

\_\_\_\_\_