

Emergency Information Card 2009-2010 School Year

Child's Last Name	Child's First Name	Grade	Date of Birth
Address	Home Telephone #	Gender M F	
Parent/Guardian Name	Business Phone #	Cell phone #	
Parent/Guardian Name	Business Phone #	Cell phone #	

School policy is to contact parents first in case of an emergency. Authorized escorts other than parent who may be called in an emergency:

Name: _____ Relationship: _____ Phone # _____ Cell # _____

Name: _____ Relationship: _____ Phone # _____ Cell # _____

Name: _____ Relationship: _____ Phone # _____ Cell # _____

PERSON(S) NOT ALLOWED TO PICK UP MY CHILD

1. _____ 2. _____ 3. _____

(*MUST HAVE MEDICAL DIAGNOSIS*)
An Inhaler or EpiPen must be provided to the teacher by the parent/guardian

NO KNOWN DISABILITY _____ ASTHMA/AIRWAY DISORDER* _____ ALLERGY TO FOOD* _____ ALLERGY TO ENVIRONMENT* _____ DIABETES* _____ GLASSES/CONTACTS _____ VISUAL IMPAIRMENT * _____ COLOR BLINDNESS* _____ HEARING AID (R) _____ (L) _____ HEARING IMPAIRMENT* _____ ADD/ADHD* _____ HYPERSENSITIVITY TO* _____	NEUROLOGICAL DISEASE* _____ MUSCULAR DISEASE* _____ ORTHOPEDIC PROBLEM* _____ SKIN DISORDER* _____ HEART PROBLEM* _____ PSYCHOLOGICAL DISORDER* _____ MIGRAINES* _____ CANCER* _____ SEIZURES*TYPE _____ GENETIC SYNDROME* _____ BLOOD DISORDER* _____ OTHER: _____
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NOTE: HEALTH INFORMATION WILL BE GIVEN TO TEACHER, EXCEL PROGRAM, AND LUNCH STAFF TO ENSURE A SAFE AND SUPPORTIVE ENVIRONMENT FOR EACH STUDENT.

RECEIVING MEDICATION? YES NO IF YES, Name of medication _____ NEEDED AT SCHOOL YES NO

PRESCRIPTION MEDICATION MUST BE ADMINISTERED BY STAFF

Child's Physician _____ Phone number _____

In the event of an accident or illness to the above-mentioned child, I _____, do hereby authorize Lamb of God Lutheran School to secure any necessary emergency surgical or medical care. Life threatening illness/injury will result in transportation to a hospital chosen by qualified medical personnel.

Date: _____ Signature of Parent/Guardian: _____