

**Emergency Information Sheet
2010-2011 School Year**

Child's Last Name	First Name	Date of Birth
Home Telephone #	Gender M F	
Street Address	City	State Zip Code
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 escort other than parent who may be called in an emergency:		
Name: _____	Relationship: _____	Phone # _____ Cell phone# _____
Address: _____		
Name: _____	Relationship: _____	Phone # _____ Cell phone# _____
Address: _____		
Out of State Contact: (In case of an emergency disaster only)		
Name: _____	Relationship: _____	Phone # _____ Cell phone# _____
Address: _____		

(*MUST HAVE MEDICAL DIAGNOSIS) An Inhaler or EpiPen must be provided by the parent/guardian	
NO KNOWN DISABILITY ASTHMA/AIRWAY DISORDER* _____ BLOOD DISORDER* _____ FOOD ALLERGY TO _____ _____ DIABETES* _____ SEIZURES*:TYPE _____ GENETIC SYNDROME* _____ GLASSES/CONTACTS _____ HEARING AID (R) _____ (L) _____ HEARING IMPAIRMENT* _____ ADD/ADHD* _____ CANCER* _____ MIGRAINES* _____	NEUROLOGICAL DISEASE* _____ MUSCULAR DISEASE* _____ ORTHOPEDIC PROBLEM* _____ POTENTIALLY SEVER REACTION TO _____ ENVIROMENTAL ALLERGIES _____ HYPERSENSITIVITY TO _____ SKIN DISORDER* _____ HEART PROBLEM* _____ VISUAL IMPAIRMENT* _____ COLOR BLINDNESS* _____ PSYCHOLOGICAL DISORDER* _____ OTHER: _____ _____ _____

NOTE: HEALTH INFORMATION WILL BE GIVEN TO TEACHERS AND LEARNING CENTER, TO ENSURE A SAFE AND SUPPORTIVE ENVIRONMENT FOR EACH STUDENT.	
RECEIVING MEDICATION? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, name of medication _____	NEEDED AT SCHOOL <input type="checkbox"/> YES <input type="checkbox"/> NO
* PRESCRIPTION MEDICATION MUST BE ADMINISTERED BY STAFF*	
Child's Physician _____	Phone Number _____
In the event of accident or illness to the above-mentioned child, I, _____, do hereby authorize Little Lambs of God Lutheran Preschool 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 or Guardian: _____