Emergency Information
2010-2011 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:____

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:____