Emergency Information Sheet

2009-2010 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:

Name:______________________________ Relationship:_______________ Phone #_________________ Cell phone#________________

Address: ____

(*MUST HAVE MEDICAL DIAGNOSIS)

An Inhaler or EpiPen must be provided by the parent/guardian

NO KNOWN DISABILITY	NEUROLOGICAL DISEASE*____
ASTHMA/AIRWAY DISORDER*_________________________________	MUSCULAR DISEASE*____
BLOOD DISORDER*____	ORTHOPEDIC PROBLEM*____
FOOD ALLERGY TO____	POTENTIALLY SEVER REACTION TO______________________________
____	ENVIROMENTAL ALLERGIES______________________________________
DIABETES*____	HYPERSENSITIVITY TO____
SEIZURES*:TYPE____	SKIN DISORDER*____
GENETIC SYNDROME*____	HEART PROBLEM*____
GLASSES/CONTACTS____	VISUAL IMPAIRMENT*____
HEARING AID (R)_________________ (L)_______________	COLOR BLINDNESS*____
HEARING IMPAIRMENT*____	PSYCHOLOGICAL DISORDER*_____________________________________
ADD/ADHD*____	OTHER:____
CANCER*____	____
MIGRAINES*____	____

***NOTE: HEALTH INFORMATION WILL BE GIVEN TO TEACHERS AND LEARNING CENTER, 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 accident or illness to the above-mentioned child, I,____________________________, do hereby authorize Lamb 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:**____