EMERGENCY INFORMATION – CONNECTIONS DAY SCHOOL

20____ - 20____ School Year

(Please fill out completely)

Student's LEGAL Name: Last: _____ First: _____ M.I.: _____ Gender: _____

Birth Date: _____ Nickname: _____ Grade in School: _____ Student Cell #: _____

Parent/Guardian **1** Full Name: _____ Home Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City: _____ Zip: _____

Parent/Guardian **2** Full Name: _____ Home Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City: _____ Zip: _____

Parent/Guardian **1** E-Mail: _____ Parent/Guardian **2** E-Mail: _____

Child resides with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other, Name/Relationship: _____

Legal Guardian: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other, Name/Relationship: _____

Emergency contact (other than Parent/Guardian): _____ Relationship: _____ Phone: _____

Emergency contact (other than Parent/Guardian): _____ Relationship: _____ Phone: _____

Physician's Name: _____ Phone: _____ Dentist's Name: _____ Phone: _____

List any medical concerns: _____

List any Allergies (food, medication, environmental or NONE): _____

Medications @ Home (Name/Time/Amount) _____

Medications @ School (Name/Time/Amount) _____

Physical Restrictions: _____ Dietary Concerns: _____

Language spoken in home if other than English: _____

If neither parent can be contacted in the case of serious injury or illness, I authorize the school to take such emergency action as may be deemed necessary, including transportation to a hospital or medical center.

_____ _____

Signature of Parent or Guardian Date

Over

STUDENT INFORMATION CONTINUED

Pupil's LEGAL Name: Last: _____ First: _____ M.I.: _____ Gender: M F

OUTSIDE AGENCIES INFORMATION:

Is the student currently seeing a **therapist** (outside of school)? ☐ YES ☐ NO If "yes" please specify the following:

Name of therapist: _____ Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Do we have permission to contact this therapist? ☐ YES ☐ NO

If "yes" please complete a Consent to Release Information form.

Is the student currently seeing a **psychiatrist** (outside of school)? ☐ YES ☐ NO If "yes" please specify the following:

Name of psychiatrist: _____ Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Do we have permission to contact this psychiatrist? ☐ YES ☐ NO

If "yes" please complete a ***Consent to Release Information*** form.

Is the student currently involved in the courts? ☐ YES ☐ NO

Is the student currently involved with a **probation officer**? ☐ YES ☐ NO

If "yes" please list the probation officer's name: _____

Phone number: _____

Do we have permission to contact the probation officer? ☐ YES ☐ NO

If "yes" please complete a Consent to Release Information form.

INSURANCE INFORMATION:

Name of Insurance Company: _____ Phone Number: _____

Address of Company: _____

Policy Holder's Name: _____ Birth Date: _____

Group/Policy Number: _____ Employer: _____