Emergency Contact Information
Forest Lake Area Schools
CO-PARENT

For Office Use Only:
Student ID:
Family ID:
Date Printed:

Please fill in all blank areas. Check the printed information and correct it if there is an error. Thank you!

Student: _____ Home Phone: _____

Grade: ___ Teacher: _____ Birth Date: _____ Gender: _____ Ethnicity: _____

Home Address: _____

City: _____ State: ____ Zip:_____ Language: _____

PLEASE LIST ONLY PARENTS OR GUARDIANS WHO LIVE AT THE ABOVE ADDRESS.

Please specify the phone type:W=Work, P=Pager, C=Cell. You do not need to repeat the home phone from above.

Parent or Guardian 1: _____ Relationship to Student: _____

Phone 1: ( ) _____ x____ Phone 2: ( ) _____

Home Language: English ___ Other:_____

Interpreter needed?: Yes ___ No___

E-mail: _____

Translate written communication?: Yes ___ No___

Parent or Guardian 2: _____ Relationship to Student: _____

Phone 1: ( ) _____ x____ Phone 2: ( ) _____

Home Language: English ___ Other:_____

Interpreter needed?: Yes ___ No___

E-mail: _____

Translate written communication?: Yes ___ No___

Brothers & Sisters: *(names, ages, and school(s) (if attending))* _____

_____ _____

_____ _____

IN CASE OF AN EMERGENCY *(Two contacts who would care for this child in case a parent or guardian cannot be reached)*

Contact 1: _____ Relationship to Student: _____

Specify phone type: H-Home, W=Work, P=Pager, C=Cell Phone 1: ( ) _____ x___ Phone 2: ( ) _____

Contact 2: _____ Relationship to Student: _____

Specify phone type: H-Home, W=Work, P=Pager, C=Cell Phone 1: ( ) _____ Phone 2: ( ) _____

Day Care Provider: _____ Phone 1: _____

Family Doctor: _____ Phone 1: _____

Hospital Preference: _____ Phone 1: _____

Our procedure is to contact a parent first. You will be asked to pick up the child and provide proper care. If we cannot reach you, we will call the emergency contacts listed above and ask them to care for your child. In an emergency, an ambulance may be called and your child may be taken to the hospital. The cost of this is the parents responsibility.

Parent or Guardian 1 Signature _____ Date _____

Parent or Guardian 2 Signature _____ Date _____

Student Name: _____ **DOB:** _____ **School Year:** _____

Dear Parent/Guardian:
Your child's health may affect his or her learning. Therefore, health information is important in planning for your child's needs at school. To ensure the best care for your child, your input and involvement is important. Please continue to update health staff as your child's health needs develop or change.

HEALTH CONCERNS

Please ✓ and explain if your child has any of the following:

☐ ***No Health Concerns*** (see below for signature)

☐ Allergies (to what: foods, medication, environmental?): _____

A food allergy will require a Special Diet Statement form signed by a medical authority

Epi-Pen Needed: ❒ Will be kept in Health Office ❒ Student will carry (MD order required)

☐ Asthma or other breathing problems: _____

Inhaler needed: ❒ Will be kept in the Health Office

❒ Student will carry & self-administer (MD order required)

☐ Lactose Intolerant: _____Special Diet Statement NOT needed

☐ Diabetes: ❒ Type 1 ❒ Type 2 Managed by: ❒ Diet only ❒Oral meds ❒ Insulin injections ❒ Insulin Pump

☐ Concussion/Brain Injury: _____ Date of injury: _____

☐ Seizures: Type _____Date of last seizure: _____

☐ Surgeries or hospitalizations during the past year:_____

☐ Activity restrictions: _____

☐ Is there a health concern that will impact your child's school day or that could result in a medical emergency:

If yes, describe: _____

_____

☐ Receives Special Education /IEP/504 Services:_____

☐ **Vision**: Date of last exam_____ ☐ No vision problem ☐ Wears glasses or contacts

Hearing: Date of last exam_____ ☐ No hearing problem ☐ Hearing loss R/L ☐ Wears hearing aid R/L

MEDICATIONS: *Throughout the year please notify the health office of any medication and/or dosage change.*
Please list **ALL** medications that your child needs DURING THE SCHOOL DAY. A completed *Authorization for Administration of Medication at School* is required each school year for prescription AND over-the-counter medications.

_____

I attest to the above information and give permission for its release for confidential use in meeting my child's health and educational needs in school. (If you do not give permission for release, contact school administration) I will contact the health office if my child's health needs change throughout the year.

Parent/Guardian signature _____ Daytime phone _____

Print Parent/Guardian name: _____ Date: _____

Parent/Guardian e-mail contact: _____

NOTE: If your child is involved with other Forest Lake School District departments, you may find that you are required to provide health information to those departments as well. This is because privacy laws such as HIPPA and FERPA prevent district personnel from sharing private health information between or among departments. We apologize for this inconvenience, but we want to make sure your child's privacy rights are protected. (4/14)