COMPLETE, SIGN AND RETURN AT REGISTRATION

Student Emergency Form

Name: ______________________ **ID#:** __________ **Birth Date:** __________

Home Address: ____

PLEASE COMPLETE THE INFORMATION BELOW

ALLERGIES: (Food, drug, insect, other) **YES / NO** If yes, please list ______________________

MEDICATIONS: YES / NO (List all prescribed or taken on a regular basis) ______________________

Condition		If you answered 'YES' to any of these questions please explain in the area below.
ASTHMA (Current diagnosis only)	YES / NO	
BIRTH DEFECTS	YES / NO	
DEVELOPMENTAL DELAY	YES / NO	
TB (Disease or positive skin test)	YES / NO	
DIABETES	YES / NO	
SEIZURES	YES / NO	
HEART PROBLEMS (Murmur/ High Blood Pressure/ Other)	YES / NO	
ADHD	YES / NO	
VISION PROBLEMS (Glasses or contacts)	YES / NO	
EAR/ HEARING PROBLEMS	YES / NO	
BONE/ JOINT PROBLEMS / SCOLIOSIS	YES / NO	
SURGERY (List when surgery was done and what for)	YES / NO	
ANY OTHER MEDICAL OR EMOTIONAL CONCERNS (Please list)	YES/ NO	

Father/Guardian name: ______________________
Home Phone: ( ) ______________________
Work Phone: ( ) ______________________
Cellular Phone:( ) ______________________

Mother/Guardian name: ______________________
Home Phone: ( ) ______________________
Work Phone: ( ) ______________________
Cellular Phone:( ) ______________________

IN THE EVENT WE ARE UNABLE TO REACH EITHER PARENT OR GUARDIAN, PLEASE LIST (3) EMERGENCY CONTACTS

Name: ______________________ Relationship: ____________ Phone: ____________
Name: ______________________ Relationship: ____________ Phone: ____________
Name: ______________________ Relationship: ____________ Phone: ____________

In the event that my child has a medical emergency at any time while on the school premises, in a school vehicle, or at a school sponsored activity, whether during the school day or otherwise, I authorize emergency measures necessary to protect my child's health and welfare. I will assume the responsibility for any fees incurred in the administration of such medical treatment.

In the event that my son/daughter transfers to another school, I authorize Morton Freshman Center High School to forward a copy of my child's medical records to the new school. Vision and hearing screening will be done as mandated, for Special Education students, transfer students and teacher referrals.

I authorize the Health Services Office at Morton Freshman Center High School to share pertinent medical information regarding my child's health with the appropriate personnel within the building. I give permission for the school nurse to discuss necessary information regarding my child's medical care with the health-care provider.

Medicaid ID Number: ______________________

X ____

MANDATORY SIGNATURE OF PARENT/GUARDIAN **DATE**

KC/Debi/Operations Common/17-18 Registration/Student Emergency Form
Update 2/2/2017

Al revrso para Espanol