

## Solvay Union Free School District – Emergency Information

*Please circle any information that is new or recently changed*

Dear Parent/Guardian: We need the following information in order to reach you if your child becomes ill or injured during school hours. Please provide the following information for our records by **returning it to the Health Office as soon as possible**.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Grade: \_\_\_\_\_

FATHER			
Contact first in the event of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Living in household with student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name: _____			
Address: _____			
Employer: _____			
Email: _____			
Phone numbers in the order in which you prefer to be called		Classification	
1 <sup>st</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
2 <sup>nd</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
3 <sup>rd</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager

MOTHER			
Contact first in the event of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Living in household with student? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name: _____			
Address: _____			
Employer: _____			
Email: _____			
Phone numbers in the order in which you prefer to be called		Classification	
1 <sup>st</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
2 <sup>nd</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager
3 <sup>rd</sup>		<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager

Sitter: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Physician: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Hospital Preference: \_\_\_\_\_

In the past year, has student:

1. Received any **immunization** not previously reported to the school?  Yes  No
2. Had any **illness, injury or operation**?  Yes  No If so, please write date and nature of illness, injury or operation: \_\_\_\_\_  
*Please send written information from the doctor regarding illness/injury/surgery.*
3. Been examined by an **eye doctor**?  Yes  No Were **glasses** prescribed?  Yes  No
4. Currently taking **medication** at home?  Yes  No If yes, name and frequency: \_\_\_\_\_
5. Does medication need to be dispensed **in school**?  Yes  No If yes, please provide **written note from doctor and your written permission**. Medicine should be brought to school in the original bottle by parent. It will be kept locked in the Health Office and administered by the nurse per doctor's written order. This applies to both prescription and "over-the-counter" medications per New York State law.

Is there anything else concerning the health of your child which the school should know in order to give your child special care?  
 (Note: this information will be shared in confidence with appropriate teachers and staff on a need-to-know basis) \_\_\_\_\_

Please give the names of two persons to be called (other than those listed above) to transport your child home or to medical care if you cannot be reached. **These persons should be available during school hours and have an automobile.**

EMERGENCY CONTACT 1		EMERGENCY CONTACT 2	
Relationship to student: _____		Relationship to student: _____	
Name: _____		Name: _____	
Address: _____		Address: _____	
Phone numbers in the order in which you prefer to be called	Classification	Phone numbers in the order in which you prefer to be called	Classification
1 <sup>st</sup>	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager	<input type="checkbox"/> Home <input type="checkbox"/> Work
2 <sup>nd</sup>	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager	<input type="checkbox"/> Home <input type="checkbox"/> Work
3 <sup>rd</sup>	<input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Cell <input type="checkbox"/> Pager	<input type="checkbox"/> Home <input type="checkbox"/> Work

In an emergency, if no person on this form is available, we will call an ambulance.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_