McGregor ISD #4
Student Emergency Contact Card

STUDENT INFORMATION

Last Name _____ First Name_____ Middle Name_____
Birth Date: _____/_____/_____ Gender: M/F Grade Level: _____ Teacher:_____

Primary Parent/Guardian Information

Name:_____
Physical Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
Email:_____

Primary Parent Guardian Information

Name: _____
Physical Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
Email:_____

Secondary Parent/Guardian Information

Name: _____
Physical Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
Email:_____

Secondary Parent/Guardian Information

Name: _____
Physical Address: _____
City/State/Zip: _____
Home Phone: _____
Cell Phone: _____
Place of Employment: _____
Work Phone: _____
Email:_____

**Note:* *Are there any COURT MANDATED custody/visitation orders limiting access to this student? YES NO (If yes, please attach legal order)*

Household Members (please list other children in the home)

Full Name	Birthdate	Gender M/F	Relationship	Age/Grade

Authorized Contact: Please list the names of relatives/neighbors/friends in close proximity to whom we may release your child or contact if you cannot be reached. **NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS, OR ADULTS LISTED ON THIS CARD.** Changes to this list must be done in the elementary or high school office.

Name	Relationship	Home/Cell Phone	Work Phone

ISD #4 STUDENT EMERGENCY MEDICAL INFORMATION AND CONSENT (CONT'D)

STUDENT_____ _____ _____ _____ _____
Last Name First Name Middle Grade Teacher

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication? YES NO

****If your child requires medication at school, all medication sent to school must be in the original prescription container with current date and the child's name. An "Authorization of Administration of Medication" form must be on file.*

Medication	Dose	Hour(s) Given

Vision and Hearing Problems (please circle if your child has any of the following)
Wears glasses/contacts: for board work for reading all the time
Wears hearing aids: Yes No Date of last eye exam: _____/_____/_____

Severe Allergies Requiring: Epi-pen Benedryl

Food Environmental Stinging Insects/Bees Medicines/Drugs
Other (please explain): _____

Current Asthma: Uses inhaler On daily medications **Current Seizures:** If circled, on medication Yes No
Diabetes: If circled, insulin dependent? Yes No
Behavior Problems:_____
Movement Limitations: _____
Other (please explain):_____
Recent illness, hospitalization, or surgery? If circled, please provide date(s) and descriptions:
_____
Medical condition that may require care or accommodation at school (please describe):
_____

EMERGENCY TREATMENT AUTHORIZATION

I/we the undersigned parent(s) or legal guardian of_____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital or clinic treatment which is deemed advisable by and is to be rendered under the general or specific supervision of medical and/or emergency room staff licensed under the provisions of the medicine practice act and the State of Minnesota.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will NOT be withheld if the undersigned or authorized adults cannot be reached.

_____is the hospital I/we prefer for emergency medical treatment of my/our child. I/we understand that the school district does NOT provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school district.

Health Insurance Information: Please circle the type of coverage you have. PRIVATE MA MNCARE

Health Plan/Group Name_____ Policy #_____

Physician/Health Care Provider_____ Phone Number_____

Dentist_____ Phone Number_____

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes in this information.

Parent/Guardian Signature_____ **Date**_____