**WOODSTOCK PUBLIC SCHOOLS** EMERGENCY INFORMATION AND ANNUAL PARENT PERMISSION CARD

**Please PRINT: Completely read and fill out BOTH sides of this card.**

|  |  |  |  |
| --- | --- | --- | --- |
| Student’s Last Name, First Name: enter text. | | | |
| Birth Date: enter text. Male Female Grade: enter text. Bus: enter text. | | | |
| Home Address: enter text. | | Home Phone: enter text. | |
| Parent/Guardian 1 Employer: enter text. | | Phone: enter text. | |
| Parent/Guardian 2 Employer: enter text. | | Phone: enter text. | |
| Child resides with:  Both Parents/Guardians Mother On  Father Only  Other | | | |
| Other persons who are authorized to act for parent in an emergency (in order of priority): **(LOCAL)** | | | |
| 1. Name of alternate & relationship: Enter text. | | Phone: Enter text. | |
| 2. Name of alternate & relationship: Enter text. | | Phone: Enter text. | |
| 3. Name of alternate & relationship: Enter text. | | Phone: Enter text. | |
| *If unable to reach any of the above in an emergency, student will be taken to the appropriate medical facility.* | | | |
| Family Physician: Enter text. | Phone: Enter text. | | Date of last Tetanus: Enter text. |
| **YES**  **NO**  Does your child take any **medication** daily? If YES, list names of medications, dosage, & time: Enter text. | | | |
| **YES**  **NO**  Does your child have any **allergies** (bee sting, medication, food, other)? If YES, explain below: Enter text. | | | |
| Allergy and symptoms of reaction: Enter text. | | Necessary treatment: Enter text. | |
| **YES**  **NO**  Does your child have a vision or hearing problem? Explain: Enter text. | | | |
| **YES**  **NO**  Wears: glasses contact lenses For: reading distance or  full-time wear | | | |
| **YES**  **NO**  Does your child have a history of any of the following health concerns: If YES, check  and explain below: enter text. | | | |
| Asthma ADD/ADHD Diabetes  Epilepsy/seizuresHeart Condition Bone Defect | | | |
| Limited Physical Activity Urinary/Bowel Problems  Diet Restrictions Other | | | |
| Comments: enter text. | | | |

**\*\*\*Parents/guardians should notify student’s teachers/bus drivers of above conditions as necessary.\*\*\* (OVER) →**

**ANNUAL HEALTH QUESTIONNAIRE**

Does student have health insurance?  **YES**  **NO**

Has your child had any major illness, injury, or surgery in the past year?  **YES**  **NO**

If yes, please explain: enter text.

**HEALTH SERVICES MANDATED BY STATE LAW OR SCHOOL BOARD POLICY**

**Physical examinations (Grade 6 only)**  If you choose your own doctor, the exam must be completed and results recorded on the blue State of Connecticut Health Assessment Record by October.

YES, by own doctor YES, by **SCHOOL** doctor

**I understand that other screenings** such as height/weight, vision, hearing, postural, and dental screenings will be performed in specific grades, as mandated by State law.

**I have read both sides of this form completely. In an emergency, I consent to have my child transported and treated. I give permission for release of information on this form for confidential use in meeting my child’s health and educational needs in school.**

|  |  |
| --- | --- |
| Parent/Guardian 1 Name: | enter text. |
| Parent/Guardian 2 Name: | enter text. |

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_