BINGHAMTON CITY SCHOOL DISTRICT

EMERGENCY CARE/CONTACT INFORMATION

PLEASE PRINT

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent, a guardian or a designated contact.

PLEASE PRINT

Last Name: _____ First Name: _____

STUDENT INFO

Student Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Grade: _____

School: _____ Teacher/Counselor: _____

PARENT/GUARDIAN CONTACT INFORMATION

Any parent with whom the child resides has the right to make decisions concerning the child in the event of an emergency and to pick up the child from school. A non-custodial parent has the right to be listed as an emergency contact unless a court order or other legal document stating otherwise has been presented to the school.

Parent / Guardian Name: _____ Home Phone: _____
(First Middle Last)

Street: _____ Apt #: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Relationship to Student: _____ Email: _____ Place of Employment: _____

Language: _____ Resides with: ☐ Yes ☐ No

Parent / Guardian Name: _____ Home Phone: _____
(First Middle Last)

Street: _____ Apt #: _____ Work Phone: _____

City: _____ State: _____ Zip: _____ Place of Employment: _____

Relationship to Student: _____ Email: _____ Cell Phone: _____

Language: _____ Resides with: ☐ Yes ☐ No

Brothers & Sisters (Oldest First)

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB:

Name: _____ DOB: _____ Name: _____ DOB: _____

OTHER CONTACT INFORMATION

Please list three people we may call if the parent(s) or guardian(s) cannot be reached in the event of an emergency. These people also have your permission to pick your child up from school during the day.

Name of Person	*Relationship*	*Language*	*Phone Number*

Signature of Parent/Guardian: _____ Date: _____

Please duplicate this form as needed for each child

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STUDENT INFO

Full name: _____
(First Middle Last)

Date of Birth: _____ Gender ☐ Male ☐ Female Grade: _____

Building: _____ Teacher/Counselor: _____

Below list any current health condition that may require attention during the school day.

ALLERGIES

List all allergies your child has:

Foods: _____ Reaction: _____

Medicines: _____ Reaction: _____

Insects: _____ Reaction: _____

Other: _____ Reaction: _____

ASTHMA Triggers: _____

Hearing Condition: _____ Heart Condition: _____

Eye or Vision Condition: _____ Corrective Lenses: ☐ Yes ☐ No

Respiratory Disorders: _____ Blood Disorders:

Nervous System Disorders: Migraines: _____ Seizures & Type: _____ Date of Onset: _____

Skin Condition: _____ Diabetes: _____

Learning Disability: _____ Physical Disability: _____

History of Communicable Disease: _____ Other: _____

PHYSICIAN INFORMATION

Primary Care Provider: _____ Telephone: _____

Specialist Care Provider: _____ Telephone: _____

Dentist: _____ Telephone: _____

Preferred Emergency Room or Hospital: _____ Medical Insurance: ☐ Yes ☐ No Provider: _____

If NO, may we have Child Health Care Plus contact you? ☐ Yes ☐ No Signature: _____

MEDICATIONS

List all Medications and dosages your child receives on a regular basis:

Will student need to take medication at school? ☐ Yes ☐ No

A written Doctor's order is necessary for medications that will be given at school.

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child. I verify that the above information is true and correct and I understand that this information may be shared with personnel involved with my child.

Signature of Parent/Guardian: _____ Date: _____

Please duplicate this form as needed for each child