

BLUE HILL PUBLIC SCHOOLS
EMERGENCY INFORMATION

PLEASE PRINT

Student Name (First, Middle, Last) Social Sec. # Birth Date Age Grade

Parent/Guardian's Name Home Phone #

Mailing Address County of Residence

Father -Daytime Phone # Father - Cell Phone # Mother- Daytime Phone #

Email Address Mother – Cell Phone #

IN AN EMERGENCY IF PARENTS CANNOT BE CONTACTED: (Please complete this section)

NOTIFY _____
Name Phone #

FAMILY DOCTOR _____ PHONE _____

PREFERRED HOSPITAL _____

We give our permission for the above named student to participate in elementary school field trips throughout this school term.

YES _____ NO _____

The teacher or other school personnel may apply first aid treatment until the family doctor can be contacted.

YES _____ NO _____

We give our consent for teachers and other school personnel to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached. YES _____ NO _____

Signature of Parent or Guardian

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HEALTH INFO

Please complete the health information below. This information will be recorded on your child's permanent health record.

1. Does your child have any allergies? If so, please list

2. Has your child had any illnesses or accidents this past year? If so, please list.

3. Please list any surgical procedures your child has had along with the date.

4. Does your child take any medication on a routine basis? If so, please list the medication and the reason they are taking it.

5. Does your child wear glasses? _____ Contacts? _____
Has your child had an eye exam in the last year? _____ Date: _____

6. Your child's dentist: _____
Date of last exam: _____

7. Is there any reason your child cannot participate in all physical education activities?
Yes _____ No _____ If yes, please explain _____

8. If your child has other health concerns you would like the school to be aware of, please list them: