



Unionville-Sebewaing Area Schools
2203 Wildner Road - Sebewaing, MI 48759 - 989-883-2360
www.think-usa.org

EMERGENCY CONTACT FORM

Student Name: _____

The emergency contacts you supply in this section are the people/numbers that will be called after we have tried to contact the parent/guardian contacts listed on the Registration Form. By providing their information here, it is assumed that you are authorizing these contacts to pick up your child from school in the event of an emergency. The emergency contacts will only be called for emergencies involving your child should conditions arise which make it necessary for early dismissal. Otherwise a **note must be provided by a parent or legal guardian for anyone to pick up your child from school.**

Emergency Contact (required)

Name: _____

Relationship: _____

Phone First: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Second: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Third: ☐ Cell ☐ Home ☐ Work Number: _____

Emergency Contact (required)

Name: _____

Relationship: _____

Phone First: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Second: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Third: ☐ Cell ☐ Home ☐ Work Number: _____

Emergency Contact (optional)

Name: _____

Relationship: _____

Phone First: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Second: ☐ Cell ☐ Home ☐ Work Number: _____

Phone Third: ☐ Cell ☐ Home ☐ Work Number: _____



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STUDENT HEALTH FORM

Name of Student: _____ Grade _____

Address: _____ Phone: _____

Doctor's Name: _____ Date of last physical: _____

Dentist's Name: _____ Date of last exam: _____

Does the student have any of the following (please check each listing)?

Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	To medication, food, pollen etc? List: _____ Requires Epi-Pen? Requires Emergency Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed by doctor? Requires Inhaler? Requires emergency treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Bee Sting Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed by doctor? Requires Epi-Pen? Reaction: Difficult Breathing? Hives? Local Swelling? Requires emergency treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Take Insulin? Comments: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy /Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication _____ Date of Late Seizure: _____	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosed by Doctor? Medication: _____ Physical restrictions? Comments: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

List medical information, such as any serious illnesses, surgeries or injuries in the past 12 months:



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MEDICATION FORM

Student Name: _____

I give my permission for (child's name) _____
to receive basic health care treatment, health education, and emergency care by school personnel.

Parent/Guardian Signature: _____ Date: ____/____/____

This consent will be in effect for the **current** School Year.
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PLEASE PRINT:

Parent1/Guardian: _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____

Parent2/Guardian: _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____

Emergency Contact: _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____