EMERGENCY INFORMATION FORM

BIRMINGHAM PUBLIC SCHOOLS **SCHOOL:**

Student Name	Grade	Sex
Student Home Address		
City	Zip Code	
Birth Date	Student Home Phone	

Student Directory Listing Permission ☐ **Yes** ☐ **No** **Photo/Video Permission** ☐ **Yes** ☐ **No**

Residing in home with Student: ☐ Mother ☐ Father ☐ Step-parent ☐ Guardian
(Check all that apply)

PLEASE READ THESE DIRECTIONS CAREFULLY BEFORE COMPLETING REMAINDER OF THIS FORM.

- **Number the Emergency Call Order # boxes** in the order parents/guardians and emergency contacts are to be called.
- **Circle the preferred telephone number** to call in case of emergency.
- **Check the Authorized Treatment box** to indicate the person(s) with legal authority to consent to medical treatment.
- **Check the Authorized Pick Up box** to indicate the person(s) having permission to pick up your child from school.

HOME INFORMATION – PARENT /GUARDIAN RESIDING IN THE HOME WITH THE STUDENT

Emergency Call Order #		Male Parent/Guardian Name	Relationship	Home Phone	
Home Address			Cell Phone	Email	
Place of Business	Business Phone		Pager	Authorized Treatment ☐	Authorized Pick-Up ☐

Emergency Call Order #		Female Parent/Guardian Name	Relationship	Home Phone	
Home Address			Cell Phone	Email	
Place of Business	Business Phone		Pager	Authorized Treatment ☐	Authorized Pick-Up ☐

HOME INFORMATION – PARENT RESIDING ELSEWHERE

Emergency Call Order #		Male Parent/Guardian Name	Relationship	Home Phone	
Home Address			Cell Phone	Email	
Place of Business	Business Phone		Pager	Authorized Treatment ☐	Authorized Pick-Up ☐

Emergency Call Order #		Female Parent/Guardian Name	Relationship	Home Phone	
Home Address			Cell Phone	Email	
Place of Business	Business Phone		Pager	Authorized Treatment ☐	Authorized Pick-Up ☐

EMERGENCY CONTACTS OTHER THAN PARENTS, GUARDIANS OR STEP-PARENTS

Emergency Call Order #		Name	Relationship	Home Phone	Cell Phone	
Home Address:				Pager		
Place of Business		Business Phone		Authorized Treatment ☐	Authorized Pick-Up	☐

Emergency Call Order #		Name	Relationship	Home Phone	Cell Phone	
Home Address:				Pager		
Place of Business		Business Phone		Authorized Treatment ☐	Authorized Pick-Up	☐

I acknowledge the information on this form is true and accurate. I am responsible to notify the appropriate school personnel when this information changes.

Parent Signature_____ **Date** _____

HEALTH INFORMATION

DOES YOUR CHILD HAVE ANY SPECIFIC PHYSICAL and/or HEALTH PROBLEMS? ☐ **YES** ☐ **NO**
CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOUR STUDENT HAS.

Asthma ☐	**Blood Abnormalities** ☐	**Cardiac** ☐	**Diabetes** ☐	**Neurological** ☐	**Psychological** ☐	**Orthopedic** ☐
Convulsive Disorder/Seizure ☐		**Other: Be Specific**			**Other: Be Specific**	

LIST ANY MEDICATION(S) THE STUDENT IS ALLERGIC TO: (Be Specific)

_____

_____

LIST ANY OTHER ALLERGIES THE STUDENT MAY HAVE – BE VERY SPECIFIC WHEN LISTING

☐	**Food (e.g.) peanuts**	☐	**Products (e.g. Latex)**
☐	**Insects**	☐	**Other (e.g. molds, dust)**

LIST PHYSICIANS (S) OR SPECIALIST(S) PROVIDING CARE TO ANY OF THE ABOVE MEDICAL OR ALLERGY CONDITIONS:

Condition:	Doctor's Name	
Address	City	Zip
Condition	Doctor's Name	
Address	City	Zip

LIST ANY MEDICATION(S) THE STUDENT IS TAKING AND THE REASON FOR THE MEDICATION.

_____

PERMISSION TO ADMINISTER MEDICATION FORMS ARE REQUIRED FOR ANY OF THE FOLLOWING MEDICATIONS ADMINISTERED AT SCHOOL (forms are available in Attendance Office). Please check those medications that will be administered at school.

☐	**Epi Pen**	☐	**Benadryl**	☐	**Peak Flow Meter**
☐	**Blood Sugar Test**	☐	**ADHD**	☐	**Any Prescription Medication (e.g., Tylenol 3)**

STUDENT'S PRIMARY PHYSICIAN: _____ **Phone Number** _____

Address _____ City & Zip _____

HEALTH INSURANCE COMPANY _____Policy Number _____

IN CASE OF EMERGENCY the school authorities have my permission to take such action as they deem necessary. _____
Parent/Guardian Signature Date

Emergency personnel have the legal right "to save life or limb" so no child's life is in danger when a parent cannot be contacted. However, some emergency personnel, including physicians and hospitals, wait until a parent is present before initiating treatment. Some hospitals may be willing to proceed in the absence of a parent if a WITNESSED SIGNATURE is available. Please read and check **ONE** of the following statements. **(Witnessed signature required.)**

In case of an injury or illness involving my son/daughter, _____, and when neither parent/guardian can be reached at the phone numbers provided, **WE AUTHORIZE** emergency personnel, as well as the attending physician and hospital personnel to take such action and give such treatment as they deem advisable for our child's comfort and well-being.

In case of an injury or illness involving my son/daughter, _____, and when neither parent/guardian can be reached at the phone numbers provided, we **DO NOT** give our consent for any medical treatment, including where illness or injury may require emergency treatment. We direct the District authorities, emergency personnel and any medical professional, hospital or medical facility to take no action whatsoever until we have been contacted. **NOTE TO PARENTS/GUARDIANS: This provision shall not apply to an emergency in which the child's life is in danger.**

_____ _____ _____ _____
Parent/Guardian Signature Date **Witness Signature (Required)** Date