2016-2017 EMERGENCY AND DISMISSAL FORM

Family Name:_____ Today's Date: _____

Student Name: _____ Grade: _____ Date of Birth:_____

Student Name: _____ Grade: _____ Date of Birth:_____

Student Name: _____ Grade: _____ Date of Birth:_____

Student Name: _____ Grade: _____ Date of Birth:_____

Home Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

Mother Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Father Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

In the event of an emergency, whom do we call FIRST? (circle one) M F Other_____

PICKUP ARRANGEMENTS

How will your child(ren) usually be dismissed after school? (Circle one)

BUS CAR WALKING AFTER SCHOOL CARE OTHER_____

Additional person(s) authorized to pick up your child:

Name: _____ Relationship: _____

Contact Info: _____

Name: _____ Relationship: _____

Contact Info:_____

HEALTH INFORMATION AND EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Please list any special health conditions or allergies your child(ren) may have:

_____

Family Doctor/Clinic: _____Phone: _____

Family Dentist: _____ Phone: _____

If emergency treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the hospital emergency room. Likewise, your signature below authorizes the release of medical records pertinent to such an emergency room visit as the school district may require for its files. This is a general authorization and is not sufficient for the release of confidential information protected by Federal Law.

Parent/Guardian Signature: _____ Date:_____