British International School of Boston

Student Emergency Form 2015-2016

Student Data:

Last Name ______ First Name ______ Middle Name ______

Gender ______ Date of Birth ______ Year Group ______ Teacher ______

Residence Data:

Street ______

Apt. ______ City ______ State ______ Zip Code ______

Home Phone ______ Household Email ______

Contact Information (Parent/Guardian):

Parent/Guardian 1:

Name ______

Relationship ______ Street ______

Apt. ______ City ______ State ______ Zip Code ______

Home Phone ______ Mobile Phone ______ Pager/Other Phone ______

Email 1 ______ Email 2 ______

Occupation ______ Employer ______

Employer Address ______

City ______ State ______ Zip Code ______ Work Phone ______

Parent/Guardian 2:

Name ______

Relationship ______ Street ______

Apt. ______ City ______ State ______ Zip Code ______

Home Phone ______ Mobile Phone ______ Pager/Other Phone ______

Email 1 ______ Email 2 ______

Occupation ______ Employer ______

Employer Address ______

City ______ State ______ Zip Code ______ Work Phone ______

Emergency Contact Data (Other than Parents):

Contact 1:

Name ______

Relationship ______ Street ______

Apt. ______ City ______ State ______ Zip Code ______

Home Phone ______ Mobile Phone ______ Pager/Other Phone ______

Email 1 ______ Email 2 ______

Contact 2:

Name ______

Relationship ______ Street ______

Apt. ______ City ______ State ______ Zip Code ______

Home Phone ______ Mobile Phone ______ Pager/Other Phone ______

Email 1 ______ Email 2 ______

Call Priority: please prioritize names and numbers of individuals (listed above) in the order you wish us to call in an emergency:

	Name	Relationship	First Phone	Second Phone	Third Phone
Call 1st					
Call 2nd					
Call 3rd					
Call 4th					

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to Children's Hospital Boston if necessary.

Preferred Hospital ______ City ______ Phone ______

Medical Practitioner Data:

Primary Care Physician:

Name ______

Practice ______

Address ______

City ______ State ______ Zip Code ______

Phone 1 ______ Phone 2 ______ Fax ______

Dentist:

Name ______

Practice ______

Address ______

City ______ State ______ Zip Code ______

Phone 1 ______ Phone 2 ______ Fax ______

Student Health Data:

Health Insurance Provider ______ Policy Number ______

List All Allergies (food/med./insect/environ.): ______

List All Medications currently taken by child: ______

Check all that apply:

☐ Asthma	☐ Heart Condition: *(Specify)* ______
☐ Seizure Disorder	☐ Hearing Problems: *(Specify)* ______
☐ ADD/ADHD	☐ Vision Problems: ☐ *Glasses* ☐ *Corrective Lenses* *Other* ______
☐ Migraines	☐ Other: *(Specify)* ______
☐ Depression	

I give permission for the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment.

Signature ______ **Date** ______