EMERGENCY INFORMATION

ARLINGTON PUBLIC SCHOOLS

This form must be completed by the parent/legal guardian each year and must be returned on the ***second day of school.***

PRESS HARD/PRINT

STUDENT NAME (LAST, FIRST, MIDDLE)	GENDER M F	BIRTH DATE (MM/DD/YY)	GRADE	ROOM #
ADDRESS WHERE STUDENT LIVES	ZIP CODE	HOME TELEPHONE ( )		

WITH WHOM DOES THE STUDENT LIVE?	LANGUAGE OF CORRESPONDENCE
PARENT OR LEGAL GUARDIAN (LAST, FIRST, MIDDLE)	E-MAIL ADDRESS
ADDRESS (IF DIFFERENT FROM STUDENT'S)	WORK/DAY TIME TELEPHONE ( ) / CELL PHONE ( )
PARENT OR LEGAL GUARDIAN (LAST, FIRST, MIDDLE)	E-MAIL ADDRESS
ADDRESS (IF DIFFERENT FROM STUDENT'S)	WORK/DAY TIME TELEPHONE ( ) / CELL PHONE ( )

PERSONS TO BE CALLED WHEN PARENT(S) CANNOT BE REACHED AND TO WHOM THE SCHOOL MAY RELEASE YOUR CHILD DURING AN EMERGENCY SITUATION

Health information about your child will be shared with this person ONLY as it relates to the specific reason he/she is being called.

(LAST NAME, FIRST NAME, MIDDLE INITIAL)	RELATIONSHIP TO STUDENT	DAYTIME TELEPHONE NUMBER
1)		( )
2)		( )
3)		( )

INSURANCE/PHYSICIAN INFORMATION:

NAME OF STUDENT'S REGULAR DOCTOR	TELEPHONE NUMBER ( )	
Does your child have health insurance? ❑ Yes ❑ No	INSURANCE PROVIDER NAME	INSURANCE IDENTIFICATION NUMBER

MEDICAL INFORMATION

Check the appropriate box to indicate any current health condition that may require attention during the school day. Please notify the school nurse if your child has a severe or life-threatening allergic reaction to any foods or other allergens. The school nurse will work with you to develop a care plan for your child. *(A copy of the Care Plan is available from the School Clinic or the School Health website)*

❑Life-Threatening Allergies (list all that apply)
- ❑Foods ______
- ❑Medicines ______
- ❑Other ______

❑Diabetes
❑Hearing Problems ❑Hearing aid(s)
❑Heart Problems
❑Hemophilia
❑Physical Disability (be specific)______
❑Asthma or other breathing problems
❑Seizures
❑Cancer — Concurrently under treatment? _ Yes _ No
❑Vision Problems ❑Glasses ❑Contacts
❑Other (Be specific, use other side if necessary)

MEDICATIONS (ex. Epipen, glucagon, inhaler, Diastat, insulin, etc.)
Has your child been prescribed any emergency medications? Please list ______
What medications does your child take at school? ______
What medications does your child take at home? ______
If your child is unable to leave school at the normal time due to an emergency, are there medications that your child must take? Please list medication and indicate reason. ______

MEDICATION AUTHORIZATION FORMS MUST BE COMPLETED FOR ANY MEDICATION(S) TO BE GIVEN AT SCHOOL.
These forms may be obtained from the school clinic staff, or on the School Health website:
(*www.apsva.us/schoolhealth*)

I understand that the above information and the results of hearing and vision screening may be shared with my child's teacher(s), principal or other school staff as needed. I give permission for my child's immunization information to be entered into the state immunization registry. I also understand that in the event of a communicable disease issue that may affect others, information may be shared with Public Health. No other protected health information will be shared without my permission. This information will be kept in the clinic and with authorized school staff, and may be used by school health staff, my child's teachers, principal, or other school staff as needed. The school has my permission, in an emergency, when I cannot be contacted, to take my child to the nearest emergency room, and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child. A copy of this page will be given to the Emergency Medical Services (EMS) staff who respond to a 911 call.

SCHOOL CLOSINGS, DELAYS, EARLY DISMISSALS AND OTHER EMERGENCIES

Should it be necessary to close school during the day, the child indicated above has been instructed to:
❑Ride home on his/her regular bus ❑Walk directly home
❑Go to the home of (name) ______ (address) ______
❑My child is enrolled in after-school Extended Day/Check-In Program and should go there.
❑Other instructions have been given to the child (specify here) ______

Parent/Guardian Signature: X ______ Date: ______

Distribution: **White:** Nurse; **Yellow:** Office; **Pink:** Elem. - Home Room Teacher; Middle - TA; High - 3rd Period Teacher

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IMPORTANT: PLEASE NOTIFY SCHOOL STAFF OF ANY CHANGES TO THE ABOVE INFORMATION