Foundation Academy EMERGENCY CONTACT & STUDENT HEALTH FORM (PART 1)

I understand that providing current emergency contact information is critical to the safety and well-being of my child. My signature on this form certifies my understanding and commitment to provide updates (in writing) of any and all changes in contact information for myself, and my emergency contacts, within 24 hours of any change, to the school administrative assistant/secretary and my child's classroom teacher(s).

STUDENT Last Name: _____ First Name: _____ Middle Name: _____

Age: _____ Date of Birth: ____/____/____ Gender: ☐ M ☐ F

Home Address _____

PRIMARY PARENT/GUARDIAN Last Name: _____ First Name: _____

Relationship: _____ Employer: _____ Work Phone: _____

Best Daytime Phone Number: _____ Best Language: ☐ English ☐ Spanish ☐ Other: _____

SECONDARY PARENT/GUARDIAN Last Name: _____ First Name: _____

Relationship: _____ Employer: _____ Work Phone: _____

Best Daytime Phone Number: _____ Best Language: ☐ English ☐ Spanish ☐ Other: _____

LOCAL EMERGENCY CONTACTS (Adults, 18 years or older, who may be contacted in the event of an emergency):

First & Last Name: _____ Relationship: _____ Phone: _____

First & Last Name: _____ Relationship: _____ Phone: _____

First & Last Name: _____ Relationship: _____ Phone: _____

I hereby give permission to the staff of Foundation Academy to secure emergency medical treatment for the above named child while under their supervision:

Name of child's physician or health clinic: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ After-Hours Emergency Number: _____

Preferred Hospital for Emergency Treatment: _____

Health Insurance Policy Name and Number: _____

Please list any critical health issues: _____

Please list any allergies: _____ Date of Last Tetanus Shot: ____/____/____

Name(s) of Person other than Parent or Legal Guardian to Whom Child maybe released (must be 18 years or older) in emergency:

_____ _____ _____

*In the event emergency medical treatment is required, I give consent for my child to be transferred to the nearest medical facility and if necessary to be treated by a qualified physician. I understand that Foundation Academy will **NOT** transport my child(ren) to the nearest medical facility. In the event that I cannot be contacted and if my designated emergency contact is not available, I understand and agree that Foundation Academy will telephone 911 for emergency medical assistance, for which I will be financially responsible.*

_____ _____ ____/____/____

Guardian Name *Guardian Signature* *Date*

EMERGENCY CONTACT & STUDENT HEALTH FORM (PART 2)

STUDENT Last Name: _____ First Name: _____

Age: _____ Date of Birth: ____/____/____ Gender: ☐ M ☐ F

MEDICAL INFORMATION

Has your child ever been diagnosed with (check if YES):

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Asthma
- ☐ Autism
- ☐ Birth Defect/Developmental Disorder
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Frequent Ear Aches/Infections
- ☐ Hearing/Ear Disorder
- ☐ Vision/Eye Disorder
- ☐ Heart Condition
- ☐ Bleeding Disorder
- ☐ Neuro Disorder (includes migraines)
- ☐ Seizure Disorder
- ☐ Speech Disorder

Is the child allergic to any medications, including over the counter ointments?

☐ No ☐ Yes, please list: _____

Does the child have any allergies (food*, latex, insect bites/stings, animals, seasonal, other)?

☐ No ☐ Yes, please list: _____

**Please request and complete the Food Allergy Form for the Lunch Program staff if student has food allergies.*

Does the child have any other medical conditions or restrictions?

☐ No ☐ Yes, please list: _____

Does the child require daily medicine or other health maintenance while at school? ☐ No ☐ Yes*, please specify:

☐ Inhaler ☐ Breathing treatment ☐ Blood glucose check ☐ Other, describe: _____

**If your child needs to take prescription medicine at school, you must provide the medication in the original prescription bottle with the child's name on it. If your child needs to take any over-the-counter medication, you must provide the specific, age-appropriate medication in the original sealed container. All medication must be brought to the health office by a parent or guardian and a Consent for Giving Medication at School Form must be completed and signed by the parent.*

Does the child take daily medicines at home? ☐ No ☐ Yes*, please specify:

Inhaler ☐ Breathing treatment ☐ Blood glucose check ☐ Other, describe: _____

DENTAL INFORMATION

Name of child's dentist: _____

Address: _____ City _____ State _____ Zip _____

Phone Number _____ After-Hours Emergency Number _____

To the best of my knowledge, the above named child does not have any health problems that would be harmful to him/her while participating in Physical Education or which would require a physical exam. I hereby give permission for the exchange of information regarding the child's medication and medical issues. Be it known that I, the undersigned parent or legal guardian of the student named above, do hereby and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment, or care to said student as in the judgment of said authority should the student be injured or stricken ill.

_____ ____/____/____

Guardian Name *Guardian Signature* *Date*