

DROUGHT SCHOOL EMERGENCY INFORMATION

NORWAY/RAYMOND JT. 7 SCHOOL DISTRICT

PLEASE BE SURE TO COMPLETE BOTH PAGES OF THIS FORM

Student Info:

First Name	Middle	Last	M	F	D.O.B.	Grade

Mailing Address	City	Zip	Home Phone

Parent Info:

Name of Father/Guardian	Place of Work	Work Phone Number	Cell Phone Number

Name of Mother/Guardian	Place of Work	Work Phone Number	Cell Phone Number

Email Address to send student info such as monthly newsletter, etc.:

Please check nationality (for statistical purposes only – state proficiency tests require this information):

- White
- Asian
- Hispanic
- African American
- Other _____

*****City & State student was born in:

Live with:

____ Mom ____ Dad ____ Both

____ Joint Custody: Days with Mom: _____ Days with Dad: _____

Comments: _____

If a child becomes ill and parents are not available contact:

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

3. Name _____ Relationship _____ Phone _____

Family Doctor

Phone

Family Dentist

Phone

Do any of the following conditions apply:

- Heart Disease** ____
- Asthma** ____
- Allergies** ____ (Please list below)
- Other** ____ (Please list below)
- None**

If so, give special instruction for care/medications:

All information given is correct and accurate to the best of my knowledge:

Signature of Parent/Guardian

Date

In the event that treatment is required and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school to exercise their own judgment in calling the physician indicated on the other side or if not available, to transport the child to a hospital emergency room. Your signature below is not sufficient for the release of confidential information protected by Federal Law.

Signature of Parent/Guardian

Date

Please sign to give permission for information to be shared with the staff of Drought (i.e. medical information such as asthma or allergies, etc.).

Signature of Parent/Guardian

Date