

DROUGHT SCHOOL EMERGENCY INFORMATION

NORWAY 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	Cell Phone

Parent/Guardian Info:

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

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

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

Permission to give out directory data (phone number, etc.) to community members:

___ Yes ___ No ___ Yes, with restrictions: _____

Student's nationality (for statistical purposes only – state proficiency tests require this information):

___ White ___ Asian ___ Hispanic ___ African American ___ Other _____

City & State student was born in:

Student lives with:

- Both mom and dad
- Joint Custody (Days with Mom: _____ Days with Dad: _____)
- Guardian (State relationship to student: _____)

Comments: _____

If a child becomes ill and parents are not available contact (in order, please)(please list at LEAST 2):

Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone
Name	Relationship	Home Phone	Cell Phone

Medical Info:

Family Doctor	Phone	Family Dentist	Phone

Do any of the following conditions apply to the student?

	Asthma		Heart Disease
	Allergies (Please list below and treatment necessary)		Other (Please list below)

Please sign below to all three areas:

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

Signature of Parent/Guardian	Date
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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
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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
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Office Use Only		
___Phy. Ed.	___Physical	___Tech. Accept. Use
___Video/Web	___ Cell Phone	___ Walking/Bicycling