

**TRI-COUNTY SPECIAL EDUCATION COOPERATIVE
EMERGENCY FORM**

LAST NAME _____ FIRST _____ MIDDLE _____ BIRTHDATE _____

SOC. SECURITY # _____ MALE _____ FEMALE _____ SCHOOL DISTRICT # _____

SCHOOL ATTENDING _____ TEACHER'S NAME _____ GRADE _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE# _____ CELL PHONE # _____

FATHER'S NAME _____ MOTHER'S NAME _____ GUARDIAN _____

CHILD LIVES WITH: (circle) FATHER MOTHER STEPPARENT GUARDIAN OTHER _____

NAMES AND AGES OF OTHER CHILDREN IN THE HOME _____

MOTHER'S EMPLOYER AND PHONE NUMBER _____

FATHER'S EMPLOYER AND PHONE NUMBER _____

GUARDIAN'S EMPLOYER AND PHONE NUMBER _____

PERSONS TO CALL IF PARENT/GUARDIAN CANNOT BE REACHED

1. _____ PHONE: _____

2. _____ PHONE: _____

PERSONS AUTHORIZED TO PICK CHILD UP FROM SCHOOL:

1. _____ PHONE: _____

2. _____ PHONE: _____

PUBLIC AID MEDICAL CARD RECIPIENT # _____ (9 digit number)

CHILD'S NAME AS IT APPEARS ON THE MEDICAL CARD _____

CHILD'S FAMILY DOCTOR OR PEDIATRICIAN _____ PHONE _____

PLEASE LIST NAMES OF ALL SPECIALITY PHYSICIANS THAT SEE YOUR CHILD(neurologist, cardiologist, ENT, pulmonologist, gastroenterologist, ophthalmologist, etc.) _____

VISION PROBLEMS: _____ HEARING PROBLEMS: _____

MEDICATIONS TAKEN REGULARLY: _____

ANY KNOWN HEALTH CONDITIONS OR SPECIAL HEALTH NEEDS: _____

ALLERGIES: _____ MEDICATION: _____ FOOD: _____

ENVIRONMENTAL: _____

I CONSENT TO SHARING THIS EMERGENCY INFORMATION WITH MY CHILD'S BUS DRIVER/ BUS AID _____ (PLEASE INITIAL)

IF MY CHILD BECOMES ILL OR REQUIRES EMERGENCY CARE AND I CANNOT BE REACHED, CONTACT MY CHILD'S DOCTOR OR TAKE MY CHILD TO THE NEAREST EMERGENCY TREATMENT. MY SIGNATURE INDICATES THAT THE SCHOOL AND HOSPITAL HAVE MY PERMISSION TO TAKE THE NECESSARY EMERGENCY CARE AND ADMINISTER TREATMENT. I AGREE TO ASSUME RESPONSIBILITY FOR ANY EXPENSES INCURED AT SUCH TIME.

PARENT/GUARDIAN _____ DATE _____

(COMPLETE AND RETURN FORM IMMEDIATELY, NOTIFY SCHOOL OF ANY CHANGES DURING THE SCHOOL YEAR.)