2013-2014 STUDENT EMERGENCY INFORMATION BISHOP GARRIGAN JR/SR HIGH SCHOOL

STUDENT NAME_____ GRADE ___ STUDENT CELL # _____

DEAR PARENT: On rare occasions a student is injured or may become seriously ill. We will try to notify a parent first unless instructed otherwise. Therefore we need the following information:

MOTHER'S NAME_____ PHONE: HOME_____

ADDRESS_____ WORK_____ CELL_____

EMAIL _____

FATHER'S NAME_____ PHONE: HOME_____

ADDRESS_____ WORK_____ CELL_____

EMAIL _____

If school is unable to reach a parent, please call:

NAME_____ PHONE: HOME_____

ADDRESS_____ WORK_____ CELL_____

NAME OF DENTIST_____ PHONE_____

NAME OF EYE DOCTOR_____ PHONE_____

Does student wear CONTACT LENSES? Yes No (Circle One)

If we are unable to reach any of the above in an emergency, may we call Kossuth Regional Health Center?
Circle One YES NO

If your answer is no, what course of action shall we take?_____

MEDICAL INFORMATION

*HEALTH CONDITIONS
Please circle yes or no:

CURRENT MEDICATIONS:

DIABETES Yes No _____

ASTHMA Yes No _____

ALLERGIES Yes No _____

OTHER CONDITIONS OR OTHER MEDICATIONS?_____

I give permission for my student to carry and self-administer medications listed above. Yes No (Circle one)

GENERAL HEALTH INFORMATION YOU FEEL THE SCHOOL SHOULD HAVE:

_____

_____

I give permission for my student to receive one or two 500 milligram tablets of Tylenol, or one 200 milligram tablet of Advil, age appropriate, for physical complaints, without a phone call. Yes No (Circle One)

Sharing of Information: This information may be shared among school personnel that have contact with my child and have a need to know. Please circle one: Yes No

I authorize BGS to use any photographs or articles about my child for publicity purposes. Please circle one Yes No

If the student drives a vehicle to school, please fill in the following:

Make/Model_____ Color_____ License Plate #_____

DATE_____ _____

Signature of Parent/Guardian

Please fill out and return to the Principal's office as soon as possible.