EMERGENCY CONTACT INFORMATION

Site: _____ Teacher's Name: _____ Room#: _____ FID#_____

Child's Full Legal Name _____ Male ☐ Female ☐ Birth Date: _____ /_____ / _____

A. Name of parent/guardian _____ ☐ Child lives with parent

Contact Phone: (_____) _____ Alternate Phone or Work Phone: (_____) _____

Address: _____

Email address of parent/guardian: _____

B. Name of parent/guardian _____ ☐ Child lives with parent

Contact Phone: (_____) _____ Alternate Phone or Work Phone: (_____) _____

☐ Same as above or Address: _____

Email address of parent/guardian: _____

Is there any person(s) NOT authorized to pick child up from school? (If yes, court order must be in Child File)

☐NO ☐ YES, Name of Person _____

Medical Insurance Type: ☐ Medi-Cal ☐ CHDP ☐ TriCare ☐ Private ☐Other: _____ ☐ None

Insurance Provider: _____ I.D.#: _____ Issue/Effective Date: _____

Physician: _____ Address: _____

Phone: (_____) _____ Fax: (_____) _____

Dental Insurance Type: ☐ Medi-Cal/Denti-Cal ☐ CHDP ☐ TriCare ☐ Private ☐Other: _____ ☐ None

Dental Insurance Provider _____I.D. # _____ Issue/Effective Date: _____

Dentist: _____Address: _____

Phone: (_____) _____ Fax: (_____) _____

HEALTH INFORMATION

Circle any of the following conditions that apply to the child: Food Allergy, Special Diet, Asthma, Diabetes, Anemia, Sickle Cell, Seizure, Fainting, Epilepsy, Heart Condition, Severe allergy, Other_____ ☐ N/A

Details & Reactions (please explain) _____

Are any of the above life-threatening? ☐ No ☐ Yes if yes, please explain: _____

Physician/Specialist's name and phone number: _____(___)_____

Medications that child uses/takes at school: _____

IN THE EVENT OF AN EMERGENCY

In the event of an emergency during which there is a belief that my child's life may be at risk, or a belief there is a risk of permanent injury to my child, I understand that NHA staff will call Emergency Medical Services and provide necessary treatment for my child's urgent medical care. In the case of an emergency incident, I authorize NHA to engage Emergency Medical Services, provide necessary treatment, and to share my child's health records with emergency service providers. I understand that I will be immediately notified of an emergency situation.

Parent/Guardian's Signature: _____ Date: _____ /_____ /_____

OTHER PERSONS AUTHORIZED TO PICK UP CHILD FROM EHS/HS SITE

Name_____ Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

Name _____Phone (_____) _____Relationship _____

☐ Additional names have been added to the back of this document.

Print Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____ /_____ /_____