

Parents: Please be certain that this information is current and complete, as it will be used by the school in the event of an emergency. The information on Page 1 is used for quick referencing in an emergency situation. Please complete all pages, and return to school by August 1. **Students will not be allowed to attend school if this completed form is not on file prior to the first day of school.**

THE SUMMIT SCHOOL STUDENT EMERGENCY/CRISIS INFORMATION

ATTACH
STUDENT PHOTO

STUDENT INFORMATION updated for School Year _____ - _____

Student _____
Last First Middle

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____

Student DOB _____ **Sex** M F **SSN** _____

HT _____ **WT** _____ **Eye Color** _____ **Hair Color** _____ **Distinguishing marks** _____

Race: Asian African-American American Indian Hispanic White Other _____

MOTHER'S NAME _____

Mother's Work Phone _____

Mother's Cell Phone _____

Mother's email _____

FATHER'S NAME _____

Father's Work Phone _____

Father's Cell Phone _____

Father's email _____

Student resides with: Both Parents Mother Father Other _____

Custodial Parent/s: Both Mother is the custodial parent Father is the custodial parent

Are both parents authorized to pick up child? If NO, provide a copy of legal papers regarding child's custody for our files.

Does your child have allergies? (please check) Yes No
Please list and describe (e.g., food, medications, insects, uses Epi-Pen, Other).

Does your child have any other health concerns? (e.g., Asthma, Asthma Inhaler User, ADD/ADHD, Cancer, Diabetes, Heart Condition, etc.) Please list and describe the condition.

Does your child take any medication on a regular basis? Please list below and have your student's physician complete medication administration form/s if medications are needed in school.

Meds taken at school

Dosage & Time

Meds taken at home

Dosage & Tiime

2-Day Crisis Emergency Meds Supply (a 2-day supply must be kept at school w/physician signed permission to dispense).

Meds

Dosage & Time (s) Given

Permission to Take Advil/Tylenol: Advil Tylenol None _____

If Advil or Tylenol is permitted, a form signed by a physician must be on file at school and medication sent in original containers, labeled with the students name and amount of dosage permitted.

Permission to take any other meds (inhaler, etc.) Please list:

Date of last tetanus booster _____

Student's Physician: _____

Phone: (_____) _____ - _____

Hospital of Choice: _____

Health Insurance Co _____

Policy Number _____

Guarantor's Social Security Number: _____

Guarantor's Employer: _____

PARENTAL CONSENT FOR EMERGENCY MEDICAL TREATMENT

I authorize the administration of emergency medical treatment for my child in the event of an injury or illness during my absence.

Parent Signature: _____

Witness: _____

EMERGENCY CONTACT INFORMATION

NAME: _____

(Relationship to student): _____

Phone number(s): HOME: (_____) _____ - _____

WORK: (_____) _____ - _____

CELL: (_____) _____ - _____

Email: _____

Other names we are authorized to call in the event of an emergency?

(e.g., grandparents or other relatives). Please list name, phone and relationship to student.

EMERGENCY PICK-UP AUTHORIZATION & PERMISSION to DESIGNATE

I authorize the following persons to pick up my child from school in the event that I am unable to do so:

Designated Driver 1 _____

(Print first and last name)

Home Phone(_____) _____

Cell Phone (_____) _____ Wk Phone _____

Is this person a neighbor, relative, friend? _____

Address: _____

City: _____

Email _____

Work hours _____

Designated Driver 2 _____

(Print first and last name)

Home Phone(_____) _____

Cell Phone (_____) _____ Wk Phone _____

Is this person a neighbor, relative, friend? _____

Address: _____

City: _____

Email _____

Work hours _____

Designated Driver 3 _____

(Print first and last name)

Home Phone(_____) _____

Cell Phone (_____) _____ Wk Phone _____

Is this person a neighbor, relative, friend? _____

Address: _____

City: _____

Email _____

Work hours _____

In the event that I am not home when my child arrives from school, I permit my child to be released to the following designated persons:

1. **Name:** _____
Is this person a neighbor, relative, friend? _____
Address: _____
City: _____
Phone number (H) _____ - _____ - _____
Phone number (W) _____ - _____ - _____
Work hours _____
Cell _____
Email _____

2. **Name:** _____
Is this person a neighbor, relative, friend? _____
Address: _____
City: _____
Phone number (H) _____ - _____ - _____
Phone number (W) _____ - _____ - _____
Work hours _____
Cell _____
Email _____

Parent Signature _____

I authorize any of the employees (such as Dr. McCarthy, or an employee designated by Dr. McCarthy) to take my child home, if necessary, after 5:00 p.m.

Additional comments: _____

Parent Signature _____