ISD #4 – STUDENT EMERGENCY CONTACT CARD

(Emergency Contacts/Medical Consent (on reverse)

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill out the information on both sides of this card carefully and accurately.

STUDENT:_____ M_____ F_____ Grade_____
Last Name First Middle

_____ Home Phone _____ Birthdate _____
Home Address (Primary Residence) City Zip

_____Lives With: Both Parents Mother Father Legal Guardian
Mailing Address, if different from above City Zip Address Change? YES NO

MOTHER/GUARDIAN _____ _____ | _____
Last Name First Email Employer

_____ _____ | _____ | _____
Home Address, if different from above City Zip Home Phone Work Phone Cell Phone

FATHER/GUARDIAN _____ _____ | _____
Last Name First Email Employer

_____ _____ | _____ | _____
Home Address, if different from above City Zip Home Phone Work Phone Cell Phone

Are there any COURT MANDATED custody/visitation orders limiting access to this student? YES NO **If Yes, please attach LEAGAL ORDER**

Other children at home: _____/_____ _____/_____ _____/_____
Name Grade Name Grade Name Grade

Authorized Contacts: **Please list the names of relatives/neighbors/friends in close proximity to the school to whom we may release your child or contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD. Changes to list must be done at either the Elementary or High School Offices.**

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school

Name	Relationship	Home Phone	Cell Phone/ Work Phone

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes to be made in this information.

Parent/Guardian Signature_____ Date_____ Relationship_____

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ISD#4 - STUDENT EMERGENCY MEDICAL INFORMATION AND CONSENT

STUDENT_____ _____
Last Name First Name Middle GRADE/TEACHER

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication? YES NO

*****If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file.*

Medication	Dose	Hour(s) Given

Vision and/or Hearing Problems:
Wears glasses/contacts: for board work for reading all the time
Date of last eye exam_____ Wears hearing aid(s)

Medical Conditions: Please circle if your child has any of the following:
Severe Allergies Requiring: Epi-pen Benedryl
Food Environmental Stinging Insects/Bees Medicines/Drugs Other
Please Explain: _____
Current Asthma If circled, uses inhaler on daily medications
Current Seizures If circled, on medication? YES NO
Diabetes If circled, insulin dependent? YES NO
Behavior Problems:_____
Movement Limitations:_____
Other (please explain):_____
Recent illness, hospitalizations, or surgery. If circled, please provide date(s) and description(s); _____
_____

Medicatl Condition which might require care or accommodation at school (please describe): _____

EMERGENCY TREATMENT AUTHORIZATION

I/we the undersigned parent(s) or legal guardian of _____, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital or clinic treatment which is deemed advisable by and is to be rendered under the general or specific supervision of medical and/or emergency room staff licensed under the provisions of the medicine practice act and the State of Minnesota.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will NOT be withheld if the undersigned or authorized adults cannot be reached.
_____ is the hospital 1/we prefer for emergency medical treatment of my/our child. I/we understand that the school district does NOT provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school district.

_____ _____
Parent/Guardian Signature Date

Health Insurance Information: Please circle the type of coverage you have: PRIVATE MA MNCare

Health Plan/Group Name:_____ Policy Number:_____
Physician/Health Care Provider_____ Phone No. _____
Dentist:_____ Phone No. _____