



Bus # _____ (OR) Car Rider: _____

Student Emergency/Information Form

Basic Demographic

Student ID _____

Last 4 Digits of Social Security # _____ (Office Use Only)

Student's Full Name: _____

Gender: Male or Female Birth Date: (month/day/year) _____

Student's Phone: () _____ Cell Phone: () _____

Ethnic (circle only ONE): Are you Hispanic/Latino OR Non-Hispanic?

Race (Circle ALL that Apply): American Indian/Alaska Native Asian Black or African American Native Hawaiian/Other Pacific Islander White

Grade (this year): _____ Homeroom Teacher: _____

Student's Address: _____

Student's Physical Address: (if above is a PO Box) _____

Please give brief directions to your home: _____

Student Lives with (Circle one): Both Parents Mother Father Guardian

Parent Demographics

Mother/Guardian's Name: _____

Address: _____ Street City State Zip

Home Phone: () _____ Cell Phone: () _____

Employer's Name: _____ Phone: () _____

E-mail Address: _____

Educational Level (please circle): High School, GED, Eight or Less Years of School, More Than Eight Years (did not finish high school), Some Education After High School, Some Education After College, Community College, Technical College, Trade or Business College, Four Year College, Graduate School

Father/Guardian's Name: _____

Home Phone: () _____ Cell Phone: () _____

Address: _____ Street City State Zip

Employer's Name: _____ Phone: () _____

E-Mail Address: _____

Educational Level (please circle): High School, GED, Eight or Less Years of School, More Than Eight Years (did not finish high school), Some Education After High School, Some Education After College, Community College, Technical College, Trade or Business College, Four Year College, Graduate School

Emergency Contacts

1st Person to contact in case of an EMERGENCY (other than parents):

Name: _____ Relationship: _____ May Pick up Student? Yes, or No

Address of emergency contact: _____

Emergency Contact Phone: () _____ Cell: () _____

2nd Person to contact in case of an EMERGENCY (other than parents):

Name: _____ Relationship: _____ May Pick up Student? Yes or No

Address of emergency contact: _____

Emergency Contact Phone: () _____ Cell: () _____

ical Information

Family Doctor: _____ Phone: () _____ Hospital Preference _____

Doctor's Address: _____
Street City State Zip

Please list any allergies, physical limitations, or chronic illnesses your child has: _____

When was the last time your child saw a doctor regarding this health condition? _____

Please list any medications your child takes regularly: _____

List medications to be taken during the school day: (A completed Alleghany County Medication Form is required) _____

Family Dentist: _____ Phone: () _____

Please list other brothers/sisters in school: _____

Name: _____ Grade: _____ School: _____

Name: _____ Grade: _____ School: _____

School: _____

***High School Students Only** Student Driver's License/Learner's Permit #: _____

Early Dismissal/Bad Weather Information

On early dismissal or bad weather days, my child needs to do the following: (Please check **ONLY one**)

____ Ride regular bus home **OR** ____ Ride bus number _____ to Where: _____

____ Be picked up at school by: Name _____

____ May drive himself/herself home

____ As last resort only call: Name: _____ Phone Number () _____

SPECIAL NOTE: Calls cannot be made until all buses have departed. PLANS SHOULD BE MADE IN ADVANCE. YOUR CHILD SHOULD BE AWARE OF YOUR PLAN AND KNOW WHAT TO DO! In case of bad weather, if you are unable to listen to TV or radio stations, please have a friend or family member listen for you. Do not call the school. WE MUST KEEP PHONE LINES OPEN TO RECEIVE EMERGENCY INFORMATION FROM OUR CENTRAL OFFICE!

Are there any legal documents (custody) on file regarding your student? (circle one) YES NO

Who **MAY** pick up student – Relationship _____

Who may **NOT** pick up child – Relationship _____

Last school attended: Name: _____ Address: _____ Phone: _____

Please list any school sponsored after school activities (band, sports, drama, tutoring, etc.) in which your student plans to participate: _____

List any special education needs or classes of your student: _____

Any other information about your student you feel the school should be aware of: _____

In case of serious illness or injury, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact a physician, hospital, or emergency services and follow their instructions.

Signature of Parent/Guardian

Date

REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

School: _____ Teacher: _____ Date: _____

Name of Child: _____ Birthdate: _____

In order to keep this student in optimum health and to help maintain maximum school performance, it is necessary that this medication be given while in school.

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____ Time to be Administered: _____
Termination date for administering this medication: _____

Emergency Medications (ex: inhalers, epi-pens, insulin injections, etc.):
____ Student has been instructed on how to use and has permission to keep with him/her at school and self-administer if able to do so.
____ Student can self-administer but emergency medication should be kept in the office (or with the home base teacher).

PHYSICIAN'S SIGNATURE IS REQUIRED

Physician's Signature Date Telephone Number

Please use a separate form for each medication.

No injections will be given except in extreme emergency, such as, allergy to wasp, bee sting or anaphylactic reaction.

PARENT / GUARDIAN PERMISSION

1. I hereby authorize my healthcare provider to release the above information to Alleghany County Schools.
2. I request and give permission for the school to administer the above medication to my child during school hours. I hereby release the School Board and their agents and employees from any and all liability that may result from the administration of the above medication. I agree to send a medication form properly completed and the medication will be sent to school in an appropriate labeled container.

Signature of Parent/Guardian Date Telephone No.

School Use Only

Name of Person(s) to Administer Medication: _____

Approved by: _____ Date _____
Principal's Signature
Reviewed by: _____ Date _____
School Nurse Signature _____