Student Emergency Contact Card
Emergency Contract/Medical Consent

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on both sides of this form carefully and accurately. Please type or use ink and print clearly and legibly.

Office Use Only

CSIS# _____

Date Enrolled _____

Grade _____

Teacher/Advisor _____

❑ Custody ❑ Medical ❑ Special Needs

Student _____ _____
Last Name First Name Middle Name Home Phone

_____ _____
Home Address (Primary Residence) City State/Zip Birth date

_____ _____
Mailing Address, if different from above City State/Zip Birthplace

Mother/Guardian _____ _____
Last Name First Name Middle Name Email

_____ _____
Home Address (if different from above) City State/Zip Employer

_____
Home Phone Work Phone Cell Phone Pager

Father/Guardian _____ _____
Last Name First Name Middle Name Email

_____ _____
Home Address (if different from above) City State/Zip Employer

_____
Home Phone Work Phone Cell Phone Pager

Are there any **Court-Mandated** custody/visitation orders limiting access to this student? ❑ No ❑ Yes (please attach legal order)

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

Languages spoken at home 1. _____ 2. _____

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 form. In selecting someone to whom you authorize the release of your child, consider: (a) Would your child feel safe and comfortable with this person and family? (b) Could this person care for your child for several days? (c) Is this person prepared to handle any special medical needs required by your child?

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

Name	Relationship	Home Phone	Work or Cell Phone
Name	Relationship	Home Phone	Work or Cell Phone
Name	Relationship	Home Phone	Work or Cell 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 the foregoing information.

_____ _____ _____
Parent(s)/Guardian(s) Signature Date Relationship

Student Emergency Contact Card Medical Information and Consent

Student _____
Last Name First Name Middle Name

Medical/Health Information

Medication: Does your child require medication? ❑ No ❑ Yes

Public school employees are allowed to administer medications prescribed by a doctor upon written request of the student's parents or guardians. The medication used at school must be in its original container with the child's name, the dosage information, the drug, and physician's name printed on it. A doctor's signed notice of authorization must be provided with the prescribed medicine in its original container. In addition, the student's parents or guardians must provide written directions with the student's name, the name of the medicine, time and method of administration, dosage, possible side effects and the termination date for administering the medicine. **Telephoned permission is not acceptable.** A copy of the Surry County School Board of Education policy and a form on which to record the information will be provided to parents/guardians who request administration of medication in the schools.

Medication	Dosage	Hour(s) Given
Medication	Dosage	Hour(s) Given
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Health Insurance Information:
Please check appropriate box. ❑ Individual Health Insurance ❑ Family Health Insurance ❑ Medicare/Medicaid

Physician/Health Care Provider_____ Telephone No._____
Health Plan/Group Name _____ Policy No._____
Dentist_____ Telephone No._____

Vision and/or Hearing Problems: ***Please check appropriate box.***
❑ Wears glasses/contacts → ❑ for board work ❑ for reading ❑ all the time Date of last eye exam_____
❑ Wears hearing aid(s)

Medical Conditions: ***Please check appropriate box if your child has any of the following:***
❑ Severe allergies requiring: Allergies to: ❑ Food/Environmental ❑ Stinging Insects/Bees ❑ Medicines/Drugs ❑ Other
❑ Epi-Pen If other please explain:_____
❑ Benadryl _____

❑ Current asthma
❑ Uses Inhaler
❑ On Daily Medication

❑ Current seizures
On medication? ❑ No ❑ Yes

❑ Diabetes
Insulin Dependent? ❑ No ❑ Yes

❑ Behavior Problems_____
❑ Movement Limitations_____
❑ Other (please explain)_____
❑ Recent Illness, Hospitalization or Surgery. Please provide date(s) and description(s)._____
_____
❑ Medical condition which might require care or accommodation at school (please describe)._____
_____

Emergency Treatment Authorization

I/We, the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby give authorization and consent to the Surry County Schools to obtain emergency medical or dental care (including transportation to a medical or dental facility) as deemed necessary by a licensed health care provider for said student's health and welfare. I/We acknowledge my/our responsibility for any expense incurred in obtaining medical or dental treatment for said student. I/We further understand and agree that a reasonable effort will be made to contact me/us prior to obtaining medical or dental treatment; however, treatment will not be withheld if deemed necessary by a health care provider.

_____***is the hospital I/we prefer for emergency medical treatment of my/our child.***

_____ _____ _____
Parent(s)/Guardian(s) Signature Date Relationship