IMMANUEL SCHOOLS EMERGENCY FORM 2018-2019
High School / Junior High / Elementary

Student Name: _____ Date of Birth: _____ Age:_____
Grade: _____ M __ F __ Siblings: _____
Student Phone #:_____ Student Email: _____

1. **Legal Guardian 1 name (circle)**: Please print	2. **Legal Guardian 2 name (circle)**: Please print
Mailing Address:_____ City:_____State:_____Zip:_____ Home Ph #:_____Work:_____Cell:_____ Email:_____ Married___ Divorced___Separated___Widowed___ Remarried___ Wife's Name_____ Employer:_____	Mailing Address:_____ City:_____State:_____Zip:_____ Home Ph #:_____Work:_____Cell:_____ Email:_____ Married___ Divorced___Separated___Widowed___ Remarried___ Husband's Name_____ Employer:_____
IN CASE OF EMERGENCY, IF PARENTS CANNOT BE LOCATED, CALL:	
3. Name (print):_____ Relationship:_____ Phone:_____	4. Name (print):_____ Relationship:_____ Phone:_____

If the above named person(s) is not available, I authorize the school authorities to seek necessary medical treatment at a hospital or other medical facility. Yes ☐ No ☐ Physician:_____Phone:_____
Signature Parent/ Legal Guardian: _____ Date: _____

CURRENT HEALTH INFORMATION

Each year we attempt to bring your student's health record up-to-date. Please assist us by answering the following questions:

1. Is there a health condition which should be brought to our attention? Yes ☐ No ☐
   If yes, explain: _____ Allergies? Yes ☐ No ☐ If yes, explain:_____
   (if your student requires medication for an allergic reaction please submit a note from the doctor with medication and instructions)
2. Is physical activity limited? Yes ☐ No ☐ According to the state code, a physician's statement must be submitted in writing each year if activity is limited.
3. State code requires a parent/legal guardian to inform the school of continuing medication being taken, current dosage, and name of supervising physician:
   Medication: _____ Physician: _____
   Medication: _____ Physician: _____
   ***All prescriptions taken during school hours must be stored in the school office under the supervision of the school secretary*.**
4. Is your child receiving special counseling services? Yes ☐ No ☐
5. Student has health insurance coverage with: _____
6. **PLEASE CHECK: Tylenol / Advil may be given to my child: Yes ☐ No ☐**

_____ _____ _____ _____
Father/Guardian Signature **Date** **Mother/Guardian Signature** **Date**

☐ **Double Mailer: Please check if you need mail sent to more than the primary mailing address.**

Address: _____ City:_____ State:_____ Zip:_____

Office Use Only
☐ Power School
☐ Data Base