House School Enrollment

PURPOSE: To enable parent or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

Social Security #	Date of Enrollment	Home Room Teacher	Grade	Ethnic Group	Student ID #

Student's Full Name:____

First Middle Last

Student's Address:____

Street/Road P.O. Box City Zip Code

Parent's E-mail Address:____

Place of Birth	Student's Birth Date	Telephone Number/Cell Phone
Mothers Name	Place of Work	Work Phone Number/Cell
Father's Name	Place of Work	Work Phone Number/Cell

ALTERNATE EMERGENCY CONTACTS (People to contact if parents cannot be reached)

Name	Relationship	Phone Number
Name	Relationship	Phone Number

Student's Insurance_______________________________ Subscriber's Name________________________
(Primary)

NAME, ADDRESS, AND PHONE NUMBER OF LAST SCHOOL ATTENDED

Name____Phone______________________

Address___________________________________City______________State_________Zip__________

TO GRANT CONSENT

In case of an emergency involving my child and I cannot be reached, I hereby give consent to transport my child to the following medical care providers and hospital, and authorize these providers and hospital to give any reasonable and customary medical and health care deemed necessary:

Doctor:____Phone:____________________________

Dentist:____Phone:_____________________________

Hospital:____Phone:_____________________________

If for any reason, the above listed medical care providers or hospital cannot be reached, I authorize appropriate transport and medical care of my child to any appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concur to the need. Nothing in this section shall be construed to impose liability on any school official or school employee who, in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care.

Signature of Parent/Guardian: ____________________________________Date: ____________

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY TO WHICH A PHYSICIAN SHOULD BE ALLERTED:

___________Asthma

___________Diabetes

___________Ear/Hearing Problems: (type)__________

___________Emotional Problems: (type)____________

___________Seizures

___________Heart Problems: (type)________________

___________Hepatitis: (type)_____________________

___________Meningitis

___________Migraine Headaches

___________Muscular Weakness or Paralysis

___________Bleeding Disorders: (type)______________________

___________Infectious Diseases (type)______________________

___________Other:____

___________Allergies?____

___________Reactions to Medicine or Injections?_____________________________________

___________Hospitalized for serious illness, surgery or accidents?________________________
____

___________ Use of contact Lenses? Yes_____________ No______________

___________ Have you ever been informed of the need to be on antibiotic therapy prior to dental treatment? Yes_______ No________

___________Please add any problems not listed:
____
____
____

Notes: