School District of Laona
Emergency Contact Form

Student Name (First, Middle, Last):_____

Grade:_____ Gender:_____

Race: (Please circle one or more) White Hispanic Black Asian/Pacific Islander Amer. Indian/Alaskan

Address: _____

City:_____ State: _____ Zip Code:_____

Child Lives With (relationship: mother & father, mother, father, mother & stepfather, etc.): _____

Father's Name: _____

Employer & Address:_____ Phone: _____

Cell Phone: _____E-Mail Address:_____

Mother's Name: _____

Employer & Address: _____ Phone: _____

Cell Phone: _____E-Mail Address:_____

Person to Contact First: (Circle One) Father Mother

Name of Family Physician or Pediatrician: _____

Address: _____ Phone: _____

Name of Dentist: _____

Address: _____ Phone: _____

In case of an accident or sudden illness to your child while at school, **and we are unable to contact you,** whom do you wish us to notify? (Local, please)

_____

(Name) *(Address)* *(Phone)* *(Relationship)*

_____

(Name) *(Address)* *(Phone)* *(Relationship)*

If, in the judgment of school authorities, emergency medical treatment is needed and I cannot be reached, I authorize the school to secure immediate emergency medical treatment.

Patent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Student Health History

Name: _____ Grade: _____ Year: _____

ALLERGIES	NO	YES	EXPLANATION (please be specific)
Drugs			
Foods			
Environmental/Seasonal			
Insect bite/sting			
Other			
CHRONIC OR RECURRING CONDITIONS	**NO**	**YES**	**EXPLANATION (please be specific)**
ADD/ADHD/Autism Spectrum			
Asthma			
Cardiac			
Diabetes			
Emotional/Behavioral Disorders			
Genetic Disorders			
Headaches			
Orthopedic			
Seizure			
Other			
Does your child have a diagnosed hearing loss?			
Does your child wear glasses or contacts?			
Has your child ever been hospitalized?			
What medications has your child taken in the past year?			
What medication is your child currently taking?			

The School District of Laona respects the sensitivity and legally protected confidentiality of student health information. Your signature below allows this information to be shared with faculty/staff who need to know for the health, safety, and learning needs of your child. In the event of a medical emergency, a copy of this form may also be provided to the Emergency Medical personnel caring for your child.

Parent Signature: _____ Date: _____