

IRVINGTON UFSD

Health Office Emergency Form
(Please print and complete all sections)

Date of Birth ___/___/___
Mo Day Year

Home Room Teacher _____

LAST NAME OF STUDENT FIRST NAME HOME phone GRADE

ADDRESS

Parent/Guardian NAME (1) _____ Parent/Guardian NAME (2) _____

Reside with Student (Yes) (No)
DAY OR WORK PHONE # (_____) _____ - _____

Reside with Student (Yes) (No)
DAY OR WORK PHONE # (_____) _____ - _____

CELL PHONE # (_____) _____ - _____

CELL PHONE # (_____) _____ - _____

Email _____

Email _____

Doctor's Name _____ Phone _____

MEDICAL INFORMATION :(Confidential)

Allergies to medication, food, insect _____ epipen required yes ___ no ___

Health Condition (asthma, heart, seizures, diabetes, etc.) _____

Medications currently used (please update accordingly) _____

REQUIRED INFORMATION**

*In case of illness or injury, and your child **cannot** remain in school, a parent/guardian will be notified and your child **must** be picked up. We will **not** send your child home on the bus or if applicable to an after-school program. A child cannot leave school without an adult.*

In the event a parent/guardian cannot be reached, please list at **LEAST 2** adults who may pick up and assume temporary care of your child.

1) _____

Name Relationship Tel. # Cell#

2) _____

Name Relationship Tel. # Cell#

3) _____

Name Relationship Tel # Cell#

Information may be shared with appropriate staff members.

I, the undersigned, parent or guardian having legal custody of the above-named minor, hereby authorize officials of the Irvington Union Free School District to contact directly the persons named herein, and do authorize the named physician to render such treatment as may be deemed necessary in an emergency, for the health of said child. This form is to be used **only** in an **Emergency**, when I cannot be reached.

Parent/Guardian signature _____

Date _____