2 Lamarck Drive, Snyder, New York 14226
Main Number [716] 839-0473 • FAX [716] 370-0364 • Health Office [716] 314-7321

HEALTH and EMERGENCY CONTACT INFORMATION

Any changes to the information contained within this document throughout the school year must be shared with the school's health or administrative office.

GRADE: _____ DATE OF BIRTH: _____ SCHOOL YEAR: _____

STUDENT'S LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ ZIP: _____

STUDENT RESIDES WITH (check all that apply): MOTHER _____ FATHER _____ BOTH _____
OTHER (list name and relationship) _____

CONTACT INFORMATION:

Mother's Full Name: _____ Cell: _(_____)_____
Place of Employment: _____ Work Phone: (____)_____
Email: _____

Father's Full Name: _____ Cell: _(_____)_____
Place of Employment: _____ Work Phone: (____)_____
Email: _____

Other's Full Name: _____ Cell: _(_____)_____
Place of Employment: _____ Work Phone: (____)_____
Email: _____

Please identify below the person(s) you wish the school to contact in the event of an emergency. These are individuals *other than the ones listed above*. Please list in order of preference.

NAME	RELATIONSHIP	PHONE

Does the student wear glasses (contacts)? ( ) N ( ) Y If yes; when are they to be worn, i.e. reading, distance, always?
_____
Does the student take the bus to and from school? ( ) N ( ) Y
Does the student participate in the after school program? ( ) N ( ) Y

Provider's name and practice: _____Phone number: _____

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STUDENT'S MEDICAL DIAGNOSIS (to include allergies):

Please note that a *provider* must diagnose your child in order for the school to include it in their medical file. If we do not have anything on file that you have listed here, the health office will contact you to inquire and request that a provider send something to the school validating the diagnosis.

If the student is *NOT* new to the school and is returning, you may check this box that signifies that there have been no changes from the previous school year.

( ) My child attended last year and there are no changes to their health history

_____
_____
_____
_____
_____

Permission to Treat your Child in the Event of an Emergency:

In the rare event that reasonable attempts have been unsuccessful in contacting a parent and the student requires acute care services, please follow the directive below (initial one choice and complete required signatures).

A.

_____ (please initial) **I DO** give my consent and permission to transfer the child to _____, or the closest treatment center. I further agree that in the case of injury or a condition requiring acute care services that coverage by (insert health care coverage information)

_____
_____

will be used to cover expenses connected to such services.

Parent/Guardian Signature (print, sign and date)

_____
_____

Witness Signature (print, sign and date)

_____
_____

B.

_____ (please initial) **I DO NOT** give my consent and permission for emergency medical treatment of my child. In the event of a condition requiring acute care services, I wish the school to

_____
_____

Parent/Guardian Signature (print, sign and date)

_____
_____

Witness Signature (print, sign and date)

_____
_____

END