

**REQUIRED EMERGENCY / HEALTH INFORMATION**  
**Jackson County Central Schools      2008-09**

**STUDENT Legal/ Birth Name:** First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

**Grade** \_\_\_\_\_ **Birth date:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Mailing & Physical Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

**City:** Lakefield Jackson Other (include CSZ): \_\_\_\_\_

**E-Mail Address** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Address (if different)** \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Address (if different)** \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**Cell Phone:** (M) \_\_\_\_\_ (F) \_\_\_\_\_

**Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Siblings (names & grade)** \_\_\_\_\_

**EMERGENCY NAMES (REQUIRED)** person authorized to care for your child when you cannot be reached. In case of an emergency, our procedure will be to contact the parent at home or at work. When this is not possible (1) a designated neighbor or relative (listed below) may be called to care for your child until you can be reached; (2) School personnel may transport your child to the Lakefield or Jackson medical clinic or to the Jackson Hospital Emergency room; (3) 911 may be called to take your child to the Jackson Hospital emergency room.

Name & relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name & relationship \_\_\_\_\_ Phone \_\_\_\_\_

In the past year has your child had any of the following?

Immunizations Outside of School (what kind): \_\_\_\_\_ Date: \_\_\_\_\_

Severe Illnesses: \_\_\_\_\_ Date: \_\_\_\_\_

Severe Injuries: \_\_\_\_\_ Date: \_\_\_\_\_

Operations: \_\_\_\_\_ Date: \_\_\_\_\_

Exam of Vision or Hearing Outside of school: \_\_\_\_\_ Date: \_\_\_\_\_

Other Medical Specialist or Mental / Emotional Health Care: \_\_\_\_\_

Current Medication(s) & Food Allergies: \_\_\_\_\_

Are there any other health condition that may limit full participation in classroom activities, physical education or school lunch program?  
No \_\_\_ Yes (explain) \_\_\_\_\_

Any known health condition which may result in an **emergency**? No \_\_\_ Yes (explain) \_\_\_\_\_

If your child needs any over-the-counter (OTC) comfort medications, you will need to provide the OTC medication in the original container, labeled with your child's name, along with a note giving permission for JCC staff to administer and brought to the office.

Please list the name of any person(s) prohibited from having contact with your child: *(Please provide the school district with a copy of the legal document prohibiting contact)* \_\_\_\_\_

Custodial Arrangements (if applicable) \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Please notify us of any changes to this form