

**STUDENT EMERGENCY INFORMATION PLEASE COMPLETE BOTH SIDES AND RETURN TO SCHOOL (WHITE-OFFICE)**

Student \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Teacher/Section \_\_\_\_\_  
 Last First MI Month Day Year Listed  
 Address \_\_\_\_\_ Home Phone ( ) \_\_\_\_\_ U  
 \_\_\_\_\_ Family Physician \_\_\_\_\_  
 \_\_\_\_\_ Physician's Phone ( ) \_\_\_\_\_

**FEMALE PARENT / GUARDIAN (Circle One):**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Place of Employment \_\_\_\_\_  
 Work Phone ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_  
 Custodial Parent: YES NO (Circle One)  
 Special Custodial Court Instructions: Yes No (Circle One)

**MALE PARENT / GUARDIAN (Circle One):**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Place of Employment \_\_\_\_\_  
 Work Phone ( ) \_\_\_\_\_  
 Cell Phone ( ) \_\_\_\_\_  
 Custodial Parent: YES NO  
 Parent is responsible to provide a copy to the office

**IF UNABLE TO REACH PARENT IN CASE OF EMERGENCY THE SCHOOL MAY CONTACT AND RELEASE MY CHILD TO:**

|            |                             |                 |
|------------|-----------------------------|-----------------|
| Name _____ | Relationship to child _____ | Phone ( ) _____ |
| Name _____ | Relationship to child _____ | Phone ( ) _____ |
| Name _____ | Relationship to child _____ | Phone ( ) _____ |

RHS 3.2 rev. 4/05

PLEASE COMPLETE OTHER SIDE

**Medical Conditions / Precautions** \_\_\_\_\_ Severe Bee Sting Allergy \_\_\_\_\_ Asthma  
 \_\_\_\_\_ Latex Allergy \_\_\_\_\_ Seizure Disorder  
 (Check all that apply) \_\_\_\_\_ Medication Allergy (please list) \_\_\_\_\_  
 \_\_\_\_\_ Food Allergy (please list) \_\_\_\_\_  
 \_\_\_\_\_ Other Conditions (please list) \_\_\_\_\_

Daily medications taken by your child:

| Medication | Dosage | Times |
|------------|--------|-------|
| _____      | _____  | _____ |
| _____      | _____  | _____ |
| _____      | _____  | _____ |

Date of last Tetanus Shot (dT, TT, DPT, DT, DTaP) \_\_\_\_\_

My child has permission to receive an antacid at school YES \_\_\_\_\_ NO \_\_\_\_\_  
 My child has permission to receive acetaminophen (Tylenol) at school YES \_\_\_\_\_ NO \_\_\_\_\_  
 My child has permission to receive ibuprofen (Advil) at school (Middle and high school only) YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby give permission for my child to be treated in the health room in accordance with Ridley School District Policies and to be transported to the doctor or hospital for evaluation and/or treatment in the event of an emergency. The School Nurse may release necessary information about my child to appropriate school personnel and in the case of medical emergencies to persons or agencies rendering care to my child.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Language spoken in the home: English \_\_\_\_\_ Other: \_\_\_\_\_  
 RHS 3.2 rev. 4/05 PLEASE COMPLETE OTHER SIDE