

# EMERGENCY INFORMATION

# ARLINGTON COUNTY, VIRGINIA

This card is to be completed by parent or legal guardian and is to be returned to the homeroom teacher on the second day of school.

PUPIL (LAST NAME, FIRST NAME, MIDDLE NAME)		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (MM/DD/YY)	GRADE	SECTION	TEACHER
STREET ADDRESS				ZIP CODE	HOME TELEPHONE NUMBER (703)	
MOTHER (LAST NAME, FIRST NAME, MIDDLE INITIAL)	PLACE OF EMPLOYMENT	WORK TELEPHONE NO. ( )		PAGER/CELL PHONE NO. ( )		
FATHER (LAST NAME, FIRST NAME, MIDDLE INITIAL)	PLACE OF EMPLOYMENT	WORK TELEPHONE NO. ( )		PAGER/CELL PHONE NO. ( )		
LEGAL GUARDIAN (LAST NAME, FIRST NAME, MIDDLE INITIAL)	PLACE OF EMPLOYMENT	WORK TELEPHONE NO. ( )		PAGER/CELL PHONE NO. ( )		
WITH WHOM DOES THE STUDENT LIVE?					LANGUAGE SPOKEN AT HOME	

## FRIEND OR RELATIVE TO BE CALLED WHEN NEITHER PARENT CAN BE REACHED

Information about your child will be shared with this person ONLY as it relates to the specific reason he/she is being called.

(LAST NAME, FIRST NAME, MIDDLE INITIAL) ①	RELATIONSHIP TO STUDENT	TELEPHONE NUMBER ( )
(LAST NAME, FIRST NAME, MIDDLE INITIAL) ②	RELATIONSHIP TO STUDENT	TELEPHONE NUMBER ( )
(LAST NAME, FIRST NAME, MIDDLE INITIAL) ③	RELATIONSHIP TO STUDENT	TELEPHONE NUMBER ( )

Does your child attend an extended day program?  Yes  No

Additional information that would be helpful in contacting you: \_\_\_\_\_

ACS 07-08150 (REV. 06/2001)

**PLEASE PROVIDE MEDICAL INFORMATION ON REVERSE SIDE OF THIS CARD** ➡

★1418

## SCHOOL HEALTH INFORMATION

NAME OF STUDENT'S REGULAR DOCTOR	TELEPHONE ( )	ALLERGIES
INSURANCE PROVIDER	INSURANCE IDENTIFICATION NO.	SPECIFY ANY EMERGENCY MEDICATIONS FOR ALLERGIES

### MEDICAL INFORMATION

Check appropriate box to indicate any current health condition that may require attention during the school day. If you have additional information or issues to discuss with the nurse, please telephone her at the school clinic.

<input type="checkbox"/> Allergies (list all that apply) <input type="checkbox"/> Foods _____ <input type="checkbox"/> Medicines _____	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Physical Disability (be specific) _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Respiratory (be specific) _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizures
<input type="checkbox"/> Hearing Problems <input type="checkbox"/> Hearing Aid(s)	<input type="checkbox"/> Vision Problems: <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lens
<input type="checkbox"/> Heart Problems (be specific) _____	<input type="checkbox"/> Other (be specific) _____

List all medications, with dosages and times, your child receives: \_\_\_\_\_

### OBTAIN MEDICATION FORMS FROM SCHOOL CLINIC FOR ANY MEDICATION(S) TO BE GIVEN AT SCHOOL

I understand that the above information and the results of hearing and vision screening and immunization information may be shared with my child's teacher(s), principal or other school staff as needed. No other health information will be shared without my permission. This card will be kept in the clinic and may be used by school health staff, my child's teacher(s), principal, or other school staff as needed.

The school has my permission, in an emergency, when I (or my physician) cannot be contacted, to take my child to the emergency room of the nearest hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for the well-being of my child. A copy of this card will be given to the Emergency Medical Services (EMS) staff who respond to a 911 call.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**IMPORTANT: PLEASE NOTIFY SCHOOL CLINIC STAFF OF ANY CHANGES TO THE ABOVE INFORMATION**