Lackawanna Trail Elementary Center
School Health Services
Information Sheet for Medical Emergencies

_____ _____ _____
Full Name of Student Date of Birth Place of Birth

Student Lives With: **MOTHER** **FATHER** **BOTH PARENTS** **GUARDIAN(relationship)**

Name:_____

Home Address:_____

Home Telephone:_____

Employer:_____ Phone/extension:_____

Home Mailing Address (if different from above) _____

Bus # _____ _____

Family Physician:_____ Hospital Choice:_____

Student Dentist:_____ Phone# Dr._____ DDS_____

Below please complete the requested information for two persons (neighbor, relative, friend, babysitter) who can be called in case parent/guardians cannot be reached. It must be a person who is usually home during the day and who will provide temporary care for the student. It is preferable to have persons with their own transportation.

1. Name_____ Relation to student_____

   Address_____ Telephone_____

2. Name_____ Relation to student_____

   Address_____ Telephone_____

Please list any SPECIAL HEALTH PROBLEMS: _____

I give permission to the staff of the Lackawanna Trail School District to transport or to make arrangements for the transportation of my child to emergency medical care and to sign the permission for medical treatment declared immediately necessary by the physician in the event that the persons listed cannot be reached.

_____ _____
Signature of Parent/Guardian Date