



**DEPARTMENT OF EDUCATION
EMERGENCY INFORMATION & HEALTH
FORM SY 20____ - 20____**



Student: _____ **School:** _____
Last First Middle Initial

Date of Birth: ____/____/____ Male Female **Ethnicity:** _____ **Grade:** ____ **Rm:** ____
Month Day Year

The information provided below will be used to update demographics on PowerSchool.

Father / Guardian:		Mother / Guardian:	
Mailing Address:		Mailing Address:	
Home Address:		Home Address:	
Place of Work:		Place of Work:	
Home Phone:	Work Phone:	Home Phone:	Work Phone:
Cell Phone:		Cell Phone:	
Email:		Email:	

Mode of Transportation: Bus Rider Car Rider Walker

It is required to provide an alternate contact name and number of an adult who can pick your child up from school if you cannot be contacted. All adults will be required to show photo identification when picking up your child. Students will be released ONLY to those listed below.

	Name	Relationship to Child	Home Phone	Work Phone	Cell Phone
1					
2					
3					
4					

In the event of a foodborne illness, DOE/DPHSS are authorized to obtain stool/vomit samples from the child in the interest of Public Health. Yes No

I give permission for the ambulance to transport my child to: GMH Naval Hospital GRMC in a medical emergency. Insurance: _____

In case of an Emergency, DOE Reserves the Right to release contact information to your child's bus driver or the Superintendent of Operations, Department of Public Works. _____ (Parent/Guardian Initial)

My child is able to participate in a regular PE class and physical activities: Yes No
 If NO, a Health Care Provider's Note is required.

 Parent/Guardian Print & Signature Date

Basic Health Data

To be filled out by Parent / Guardian to effectively meet the health needs of your child at school.

Yes	No	COVID-19 RELATED INFORMATION
<input type="checkbox"/>	<input type="checkbox"/>	<u>Wearing of Mask:</u> ONLY if it is required based upon DPHSS and/or GDOE guidance: Is student able to wear a mask/face covering during the school day? IF NO ; kindly ensure that your Health Care Provider complete a mask exemption note and provide guidance on proposed accommodations to be safely implemented at school.
<input type="checkbox"/>	<input type="checkbox"/>	<u>COVID-19:</u> Did student ever test positive for COVID-19 ? If YES , when (mm/dd/year): _____
<input type="checkbox"/>	<input type="checkbox"/>	<u>Vaccination:</u> Did student receive COVID-19 Vaccination ? If YES , date of 1st dose (mm/dd/year): _____ Date of 2nd dose (mm/dd/year): _____ Booster (mm/dd/year): _____

Yes	No	Complete Checklist below regarding your Child:
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems <input type="checkbox"/> Eczema <input type="checkbox"/> Other:
<input type="checkbox"/>	<input type="checkbox"/>	Seizures Date of last seizure: _____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problem Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problem <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses
<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer Date of last asthma attack: _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to: <input type="checkbox"/> Food <input type="checkbox"/> Drugs <input type="checkbox"/> Other, specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	Allergy to: <input type="checkbox"/> Bee Sting <input type="checkbox"/> Insect <input type="checkbox"/> Type of reaction: _____
<input type="checkbox"/>	<input type="checkbox"/>	Epipen: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	Current Medication(s): _____ Reason: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Serious Illness or Injury: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Behavioral or Mental Health Concerns: _____

(Please Draw a Map to your Residence)

List the names of all your children who are attending this school from the oldest to the youngest.

Child's Name	Grade