STUDENT EMERGENCY INFORMATION

Last Name _____ First _____ Middle _____ Male _____ Female _____

Mailing Address _____ City _____ Zip _____ Grade _____

Physical Address _____ City _____ Zip _____ Birth Date _____

Home Phone _____ Mother Cell Phone _____ Father Cell Phone _____

Birthplace: City _____ State _____ Social Security # _____

To Parents - That we may be of greatest service to your child in case of accident or sudden illness, it is necessary that you give the following information.

Please check legal relationship to student.

___ Mother ___ Stepmother ___ Guardian _____ (Name) Occupation _____ Work Phone _____

Employed by _____ Address _____

___ Father ___ Stepfather ___ Guardian _____ (Name) Occupation _____ Work Phone _____

Employed by _____ Address _____

Name of person(s) with whom student lives: _____ Relationship _____

IN AN EMERGENCY WHERE NEITHER PARENT CAN BE REACHED, CALL:

Name _____ Home Phone _____ Cell Phone _____

Name _____ Home Phone _____ Cell Phone _____

CONSENT

In the event reasonable attempts to contact me or the emergency contacts at the above listed phone numbers have been unsuccessful, I hereby give my consent for:

- The transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.
- Do you have ambulance insurance? Yes / No With whom? _____

The school will attempt to reach one of the above persons, but if none of these can be reached the school nurse, principal, or teacher in charge, has our permission to use his or her discretion in securing medical aid in an emergency. IT IS UNDERSTOOD THAT NEITHER THE SCHOOL NOR THE PERSON RESPONSIBLE FOR OBTAINING THIS MEDICAL AID WILL BE RESPONSIBLE FOR THE EXPENSE INCURRED. This authorization does not cover surgery. In such cases, the provisions of Colorado Law governing informed consent and such other authorization(s) as may be required by law, shall apply.

Facts concerning the child's medical history including; allergies, medications, and any physical impairments to which a physician should be alerted are as noted on the reverse side of this form in the Health Information.

If Parent/Guardian fails to grant this consent, the school will call 911 in the event immediate medical care is indicated.

DATED _____ SIGNATURE OF PARENT OR GUARDIAN _____

ADDRESS _____

STUDENT INSURANCE

The school has the moral responsibility to encourage each participant in athletics to be covered by an accident insurance policy. The school does not provide a policy; however, the school provides an insurance option in which students may voluntarily participate. If you decide to take the school insurance option, the policy must be paid for before practice begins for that sport.

___ 1. I will carry the policy option offered by the school.

___ 2. I am carrying a policy outside of school insurance. I will assume the responsibility for costs occurred during athletic participation. The insurance company I will use is _____

DATED _____ SIGNATURE OF PARENT OR GUARDIAN _____

Clear Creek School District
Health Information Form

Student's Name _____
Last First Middle Grade

Parent/Guardian Name _____ Signature _____ Date _____

Medication Information:

Is your child taking any medications regularly? ☐ Y ☐ N

If yes, please list Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Medication name: _____ Associated health condition: _____

Is your child allergic to any medication? ☐ Y ☐ N

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

Medication name: _____ Reaction: _____

If your child must receive medication OF ANY TYPE (including prescription, non-prescription (over-the-counter), and homeopathic medications) during school hours, we ask you to consider one of the following options: (1) YOU MAY COME TO THE SCHOOL to give the medication to your child at the appropriate time; or (2) YOU MAY OBTAIN A MEDICATION ADMINISTRATION FORM from the school or online and HAVE YOUR DOCTOR indicate on the form the DRUG, DOSE, AND TIME to be given. Please be sure he/she SIGNS THE FORM. We also need a pharmacy-labeled bottle containing the medication and instructions. If the student will self-carry a medication, the physician must indicate this on the form.
YOU MAY DISCUSS WITH YOUR DOCTOR an alternative schedule of medication so that it can be given outside of school hours.
In order for your child to attend school, immunization documentation needs to be submitted to the school office by the first day of attendance. If immunization record is not complete, the student MUST see the school nurse or designee before enrollment can be completed.

Health Concerns:

Parents/Guardians are responsible for providing full details on any medical condition to the school nurse.
Please indicate below any health conditions your child has experienced, check all that apply.

☐ Allergies (list below)	☐ Fractures	☐ Prosthesis/Limb Braces	☐ Varicella (Chickenpox)
☐ Asthma	☐ Headaches	☐ Seasonal Allergies	☐ Vision Concerns
☐ ADD/ADHD	☐ Head Injury/Concussion	☐ Seizures	☐ Contacts
☐ Bowel/Bladder	☐ Hearing Concerns	☐ Skin Conditions	☐ Glasses
☐ Diabetes	☐ Hearing Aids	☐ Speech Concerns	☐ Other _____
☐ Emotional/Behavioral	☐ Heart	☐ Surgeries	☐ Other _____

If any health conditions were indicated above, please explain in detail. Specify if an individualized health care plan is needed this school year for the condition (e.g., Allergies, Asthma, Diabetes, Seizures), which must be completed annually by a physician, or if the condition has resolved.

Comments: _____

_____

_____

_____

_____

Medical Insurance Information

Insurance Company: _____ Policy # _____ Group # _____

Primary Insured's Name: _____ Relation to Insured: _____

If a parent or legal guardian cannot be notified and immediate medical care is indicated, the school will call 911.
However, the Clear Creek School District will in no case accept financial responsibility for care, see consent on reverse side.

Special Services Information

Is your child receiving special education services? ☐ Y ☐ N

Please Indicate Disability: _____

Date of last IEP: _____

Does your child have a current 504 plan? ☐ Y ☐ N

Please indicate if related to academics or health. ☐ Academics ☐ Health

This form will be given to the School Nurse after registration