

## 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.**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Allergies (list below) | <input type="checkbox"/> Fractures              | <input type="checkbox"/> Prosthesis/Limb Braces | <input type="checkbox"/> Varicella (Chickenpox) |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Headaches              | <input type="checkbox"/> Seasonal Allergies     | <input type="checkbox"/> Vision Concerns        |
| <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Head Injury/Concussion | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Contacts               |
| <input type="checkbox"/> Bowel/Bladder          | <input type="checkbox"/> Hearing Concerns       | <input type="checkbox"/> Skin Conditions        | <input type="checkbox"/> Glasses                |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Hearing Aids           | <input type="checkbox"/> Speech Concerns        | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Emotional/Behavioral   | <input type="checkbox"/> Heart                  | <input type="checkbox"/> Surgeries              | <input type="checkbox"/> 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**