

# WILLIAMSBURG SCHOOLS' STUDENT EMERGENCY INFORMATION FORM

Name \_\_\_\_\_ Teacher \_\_\_\_\_ Gr. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_  
Street (mailing if different)

Guardian #1 \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Place of Employment (Guardian #1) \_\_\_\_\_ Work Hours \_\_\_\_\_ Phone \_\_\_\_\_

Guardian #2 \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Place of Employment (Guardian #2) \_\_\_\_\_ Work hours \_\_\_\_\_ Phone \_\_\_\_\_

Family E-Mail Address: \_\_\_\_\_ Student's Place of Birth \_\_\_\_\_

Child Resides With \_\_\_\_\_

Student Siblings 1 \_\_\_\_\_ Age \_\_\_\_\_, 2 \_\_\_\_\_ Age \_\_\_\_\_, 3 \_\_\_\_\_ Age \_\_\_\_\_,

Alternate Emergency Contact: And are allowed to pick up your child from school in case of illness or early dismissal.

1st \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2nd \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Are there any specific individual(s) who do not have permission to pick up your child?

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, Name \_\_\_\_\_ Condition \_\_\_\_\_

## **ELL Section (Circle one for each)**

1. What language did your child first learn?  
English Portuguese Hebrew Japanese Spanish Other \_\_\_\_\_
2. What Language do you use when speaking with your child?  
English Portuguese Hebrew Japanese Spanish Other \_\_\_\_\_
3. What language does your child use when speaking to you?  
English Portuguese Hebrew Japanese Spanish Other \_\_\_\_\_
4. What Language does your child uses when speaking to other adults in your home?  
English Portuguese Hebrew Japanese Spanish Other \_\_\_\_\_
5. What language does your child use most often with brothers and sisters?  
English Portuguese Hebrew Japanese Spanish Other \_\_\_\_\_

**Notice of Possible Publication of Certain Student Information During the School Year.** Under the DOE regulations the school may release for publication certain information concerning you and/or your child from time to time without obtaining your consent unless you indicated now that we should not do so. The information, which may be released, includes only the student's name, class, participation in officially recognized activities. Publication may include but is not limited to newspapers, the web, television, radio, magazines etc. (INITIAL ONE)

X \_\_\_\_\_ You may release the aforementioned information concerning myself/my child without my consent while the student is in attendance in the Williamsburg School District.

X \_\_\_\_\_ You may not release the aforementioned information concerning myself/my child without my consent while the student is in attendance in the Williamsburg School District.

**Handbook, Grievance Policy, Behavior/Discipline Code:** By initialing here I am indicating that I have read each of the aforementioned and discussed them with my child.

INITIAL HERE X \_\_\_\_\_

*Please complete the reverse side of this form*

## MEDICAL EMERGENCY RECORD

*Please be as specific and detailed as possible. It allows us to provide better and more prompt care.*

Name \_\_\_\_\_ Teacher \_\_\_\_\_ Gr. \_\_\_\_\_ Date of Birth \_\_\_\_\_

Health Insurance Yes \_\_\_ No \_\_\_ Student's Health Insurance Co \_\_\_\_\_ Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**ALLERGIES** (including bee sting, drug, food,) \_\_\_\_\_  
\_\_\_\_\_

My child may require an epi-pen for his/her allergy Yes \_\_\_\_\_ No \_\_\_\_\_

**PAST AND CURRENT HEALTH PROBLEMS, ILLNESS, OR SURGERY** \_\_\_\_\_  
\_\_\_\_\_

**CHECK ALL THAT APPLY:** Hearing problems \_\_\_\_\_ Vision Problems \_\_\_\_\_ Seizures \_\_\_\_\_ Asthma \_\_\_\_\_ Migraines \_\_\_\_\_

Depression \_\_\_\_\_ Diabetes \_\_\_\_\_ Food Intolerance \_\_\_\_\_ Heart Problem \_\_\_\_\_ Kidney Problems \_\_\_\_\_

MY CHILD TAKES THE FOLLOWING MEDICATION(S) AT HOME \_\_\_\_\_  
\_\_\_\_\_

I give permission to the school nurse to share my child's diagnosis of hearing or vision problems, asthma, allergy, and/or food intolerance status with appropriate school personnel as well as information relative to my child's prescribed treatment for his or her condition.

Yes \_\_\_\_\_ No \_\_\_\_\_ INITIAL HERE X \_\_\_\_\_

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### MEDICATION STANDING ORDERS:

After careful assessment and if needed, I give my permission for the school nurse under the orders from the Williamsburg School Physician to administer the following medications to my child during school hours:

Apply Calamine lotion for itching if needed. Yes \_\_\_\_\_ No \_\_\_\_\_

Apply Vaseline to dry skin or lips Yes \_\_\_\_\_ No \_\_\_\_\_

Administer acetaminophen(Tylenol) for mild discomfort. (according to body weight) Yes \_\_\_\_\_ No \_\_\_\_\_

Administer ibuprofen(Advil/Motrin) for mild discomfort (according to body weight) Yes \_\_\_\_\_ No \_\_\_\_\_

Administer Benadryl for mild allergic reactions (according to body weight) Yes \_\_\_\_\_ No \_\_\_\_\_

If the school is unable to reach a parent, in case of serious accident or illness, I hereby authorize the school to call my child's listed physician and to follow his/her instructions and/or to call 911 and transport my child to the nearest hospital.

Yes \_\_\_\_\_ No \_\_\_\_\_ Request/Preference: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

INITIAL HERE X \_\_\_\_\_