ST. PAUL LUTHERAN SCHOOL EMERGENCY CONTACT FORM

Student Name _____ Date of Birth _____ Grade _____
(Last) (First) (Middle)

Mailing Address _____ City/Zip _____

Home Phone _____ Cell Phone _____

E-Mail Address _____

Child Lives With: Father _____ Mother _____ Stepfather _____ Stepmother _____

Other _____ Name/Names _____

Father's Name _____ Employer _____

Work Phone _____ Hours Worked _____

Mother's Name _____ Employer _____

Work Phone _____ Hours Worked _____

Step-Parent's Name (if applicable) _____

Employer _____ Work Phone _____ Hours Worked _____

If there are any child custody issues the school should be aware of, please inform the school in writing. Thank you.

In case of illness or injury please list contacts in the order that they should be given priority when called. (May include parents or step-parents listed above)

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

3. Name _____ Relationship _____ Phone _____

Physician to be notified _____ Phone _____

Dentist to be notified _____ Phone _____

If emergency treatment is required, and the parents cannot be reached immediately, the school will call the local EMS for emergency treatment and transportation to a hospital. If this is **NOT** acceptable, what do you want done in a life threatening situation?

_____

Signed _____ Date _____

Parents are responsible for informing the school if there are any changes in this information

FILL OUT THE REVERSE SIDE FOR ANY HEALTH CONCERNS

PLEASE COMPLETE THE SECTION(S) THAT APPLIES TO YOUR CHILD.

ASTHMA

1. During the school year, how often does your child have asthma attacks? _____ Date of last attack _____
2. Causes of asthma attacks: allergies ___ infections ___ weather ___ exercise ___ emotions ___
   other (specify) _____
3. Usual symptoms of attack: wheezing ___ coughing ___ difficulty breathing ___ feeling of tightness in chest ___
   bluish color of lips and fingernails ___ other (specify) _____
4. Treatment for attacks: rest ___ liquids ___ breathing exercises ___ medications (specify) _____

ALLERGIES

1. What causes an allergic reaction to your child? _____
2. Usual symptoms: redness ___ swelling ___ itching ___ hives ___ rash ___ swelling of face or tongue ___
   difficulty swallowing, talking, or breathing ___ weakness and/or dizziness ___ fainting/loss of consciousness ___
   other (specify) _____
3. Action to be taken in case of reaction at school:
   ___ Medication (specify) _____
   ___ Call parent only
   ___ Call EMS and parent immediately
   ___ Call parent and EMS if the following symptoms occur _____

SEIZURE DISORDER

1. Type of seizure _____
   Age at diagnosis _____ Average length of seizure _____ Date of last seizure _____
2. Does your child take anti-seizure medicine? Yes ___ No ___ Medication taken _____
3. List any special seizure precautions _____

HYPERACTIVITY and/or ATTENTION DEFICIT

1. Has your child been diagnosed with ADD or ADHD (circle)
2. Does your child take any medication for this condition? Yes ___ No ___
   If yes, list the name, dose and time he/she receives this medication _____
3. Does your child need to have medication during the school day? Yes ___ No ___
   If yes, please fill out a Medication Form and have your doctor sign it.
4. Does your child require any special classroom accommodations for this problem? Yes ___ No ___
   If yes, please list _____

DIABETES

Please request a diabetic care form from the school office and discuss your child's care with his teacher and office personnel.

HEART CONDITION

1. Describe the problem _____

2. Describe any activity restrictions (please discuss with your child's classroom teacher _____

_____

OTHER HEALTH NEEDS OR CONCERNS

_____

If you feel the school needs more information about your child's health needs, please contact your child's teacher. Your signature below gives permission to share the above information with all school and bus personnel. This information will be shared for the safety and well being of your child.

Parent Signature _____ Date _____