HEALTH & SAFETY EMERGENCY INFORMATION 2024-2025
Kingsley-Pierson Community School

FATHER'S INFORMATION:		MOTHER'S INFORMATION:	
Name:	Employer:	Name:	Employer:
Address:	Employer Address:	Address:	Employer Address:
Home Phone #	Work Phone #	Home Phone #	Work Phone #
Cell Phone #		Cell Phone #	

PLEASE LIST TWO PERSONS WHO HAVE AGREED TO ACCEPT RESPONSIBILITY IN THE EVENT THAT YOU CANNOT BE REACHED:			
EMERGENCY CONTACT 1:		EMERGENCY CONTACT 2:	
Name:	Home Phone #	Name:	Home Phone #
Relationship:	Cell Phone #:	Relationship:	Cell Phone #:
Address:	Work Phone #:	Address:	Work Phone #:

In the event my child becomes ill or is injured at any time at school and the school personnel cannot locate me, the School District may contact the person(s) listed on this side of the form. I hereby give my permission for the school to send my child to a local hospital for treatment and the School District shall not be responsible for the cost of that treatment. I further give the hospital permision to administer needed service(s) and under these circumstances, authorize said hospital to secure the services of a physician for my child and authorize such physicain to provide such medical and surgical services as to such physician appears necessary.

Preferred Physician:	Phone #:

Signature of Parent/Guardian:

PLEASE FILL OUT STUDENT INFORMATION ON REVERSE SIDE:

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Student Name (L, F M):				Date of Birth:	Grade:	Sex: M / F
Asthma: Y / N	Glasses/ Contacts: Y / N	Diabetes: Y / N	Seizure Disorder: Y / N			
Allergies:						
List any medications taken regularly:						
Other Notes:						

Student Name (L, F M):				Date of Birth:	Grade:	Sex: M / F
Asthma: Y / N	Glasses/ Contacts: Y / N	Diabetes: Y / N	Seizure Disorder: Y / N			
Allergies:						
List any medications taken regularly:						
Other Notes:						

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Allergies:						
List any medications taken regularly:						
Other Notes:						

Routine school Tylenol = 325 mg., 1 or 2 age appropriate.

Please list Tylenol preference:

Signature of Parent/Guardian:

Additional Comments: