

REQUIRED EMERGENCY/OFFICE INFORMATION

Jackson County Central Schools 2013 - 2014

STUDENT Legal/ Birth Name: First _____ Middle _____ Last _____

Grade _____ Birth date: _____ Social Security # _____

Physical Address _____

Mailing Address _____ Home Phone _____

City _____ St _____ Zip _____

*Have you ever attended a MN Public School? _____ If yes, please list LAST District attended _____

Are you Hispanic/Latino? No, Not Hispanic/Latino

Yes (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

What is your race? (Choose one or more) Primary Home Language _____

American Indian or Alaska Native

Asian (Far East, Southeast Asia, Indian Subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, Vietnam; examples)

Black or African American

Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa; examples)

White

MOTHER Name _____ FATHER Name _____

Mailing Address _____ Mailing Address _____

Physical Address _____ Physical Address _____

MOTHER Work Place _____ FATHER Work Place _____

MOTHER Work Phone _____ FATHER Work Phone _____

MOTHER Cell _____ FATHER Cell _____

MOTHER e-mail _____ FATHER e-mail _____

PERSON AUTHORIZED to remove child from school: _____

PERSONS NOT AUTHORIZED to remove child from school: _____

If we need to contact you for a Non-Emergent question or concern, how do you prefer to have us contact you? (Complete One)

Email _____ or Phone _____

JCC HEALTH HISTORY

Please provide the following information for the health office:

Student Name: _____ Birthday: ____/____/____ Grade: _____
Family Doctor: _____ Clinic: _____

*Please circle if your child has been diagnosed with any of the following:

- | | | | |
|--------------------------|---------------------------|--------------------------------------|----------------------------|
| Asthma | Food allergy | Depression | Learning Disability |
| Cardiac Condition | Seasonal Allergies | ADD/ADHD | Developmental Delay |
| Diabetes | Other Allergy | Gastrointestinal Disorder | Anxiety |
| Cancer | Seizure Disorder | Other Mental Health Diagnosis | |

Please explain any of the above if necessary: _____

*Will your child have an **Epi-Pen** in school for ANY allergy? Yes No If yes, for which allergy? _____

*Does your child wear contacts or glasses? Yes No

*Does your child have a hearing impairment? Yes No If yes, does he/she have hearing aids? Yes No

*Please list any major medical condition and/or surgery that your child has/had: _____

*Please list all medications your child takes (include over- the-counter medications): _____

*Please list any other specialty care or mental/emotional care that we should be aware of: _____

*Additional Information: _____

*** **Reminder** - The following forms need to be completed by a healthcare professional:

- A Special Diet Statement for the kitchen to provide food substitutions for food allergies.
- An Asthma Action Plan for students with asthma (required for students with inhalers at school).
- An Allergy Action Plan for students with severe allergies.

Emergency or Illness

In case of an injury or illness, please list contacts *in the order we should attempt calling, including parents/guardian*. Please include at least one person that does not live in the same household.

	Name	Relationship	Phone Number/s (indicate work, cell, home)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

In case of an emergency, staff will notify the first person we are able to contact from the list above. When that is not possible or the situation is emergent:

1. School personnel may transport your child to the Sanford Clinic in Lakefield or Jackson, or the Sanford Jackson Medical Center emergency room.
2. 911 may be called to take your child to the nearest emergency room they determine to be appropriate.

Signature of parent/guardian: _____ Date: _____