HAWTHORNE CEDAR KNOLLS UNION FREE SCHOOL DISTRICT
226 Linda Avenue • Hawthorne •New York • 10532 • (914) 749-2900
Day Student Emergency Form

Name of Student______________________Name of Parent(s) or Guardian(s)______________________

Mother/Guardian Home Phone#____________Work #________________ Cell#_____________________

Father/Guardian Home Phone#____________ Work # ________________ Cell#____________________

Email for Parent or Guardian ____

EMERGENCY CONTACT IF PARENT/GUARDIAN NOT AVAILABLE

Name______________________Relationship________________ **Home/Cell/ Work** Phone #________________

Name______________________Relationship________________**Home/Cell/ Work** Phone #_________________

Name of Primary Health Care Provider__________________________Telephone Number___________________

I ____________________________ give my permission to the school nurse and/or building principal to contact the above named health care provider in case of a medical emergency involving my child____________________________

Does your child currently have, or has (s)he ever had any of the following conditions:

Allergy to food	Yes/No	Concussion/Head Injury	Yes/No	Nose Bleeds	Yes/No
Allergy to medicine	Yes/No	Diabetes	Yes/No	Rheumatic Fever	Yes/No
Allergy to insect stings	Yes/No	Ear/Eye Problems	Yes/No	Stomach Ulcer	Yes/No
Asthma	Yes/No	Elevated Blood Pressure	Yes/No	TB or Positive TB test	Yes/No
Anemia	Yes/No	Fainting Spells	Yes/No	Back Pain/Scoliosis	Yes/No
Arthritis	Yes/No	Heart Problem/Murmur/Chest Pain	Yes/No	Fractured Bones	Yes/No
Cancer	Yes/No	Headaches	Yes/No	Corrective Lenses	Yes/No
Convulsions/Seizures	Yes/No	Kidney/Bladder Problems	Yes/No	Hearing Aides	Yes/No

If you answered yes to any of the above please explain: ____

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Do you have any other concerns about your child's health that you would like to share with us?

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Please list any medications your child takes:____

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In an emergency the student will be given first aid and/or transported to the nearest local hospital. You will be contacted at the phone numbers listed above. If you are not available the alternative person(s) you have listed above will be contacted. **It is very important that you inform us of any changes in this information so that we can reach you if necessary.**

I ____________________________ give permission for school personnel to administer first aid

to____________________________ and transport him/her to the hospital if necessary.

Signature of Parent/Guardian______________________________ Date____________________

Witness____ Date____________________

Medical Insurance Information: Policy Holder Name:____________________________________
Policy #_______________ ID #_______________ Medicaid # if applicable___________________
Name of Insurance Company____
Address and Telephone #____

Revised 6/25/14 ma