

Intermediate School District 917
Student Emergency Contact Information Form

School Year _____

Student Name _____ Date of Birth _____ / _____ / _____

Address _____
(Street) (Apt. #) (City) (State) (Zip)

1st Parent/Guardian Name _____ Work Phone (____) _____

Home Phone (____) _____ Cell Phone (____) _____ Other/Pager (____) _____

Email Address _____

Address _____
(Street) (Apt. #) (City) (State) (Zip)

2nd Parent/Guardian Name _____ Work Phone (____) _____

Home Phone (____) _____ Cell Phone (____) _____ Other/Pager (____) _____

Email Address _____

Address _____
(Street) (Apt. #) (City) (State) (Zip)

FOR STUDENTS NOT COMING TO SCHOOL FROM HOME, OR NOT GOING HOME FROM SCHOOL, PROVIDE THE FOLLOWING INFORMATION:

Pick-up Name & Address _____ Phone (____) _____

Return Name & Address _____ Phone (____) _____

Emergency Care Information:

Medical Emergency

In case of a medical emergency the school's procedure will be:

1. Contact parent/guardian at work/home
2. Person(s) you have designated may be asked to care for your child, including transporting your child for medical treatment, if you cannot be reached
3. Depending on the medical emergency and emergency health plan directions, 911 may be called and responders may transfer your child to a hospital emergency service. **Preferred Hospital** _____

Emergency Contacts (other than parent)*

<u>Name</u>	<u>Relationship to Student</u>	<u>Daytime Phone Number</u>
1. _____	_____	(____) _____
2. _____	_____	(____) _____
3. _____	_____	(____) _____

**At minimum, three different phone numbers are needed to reach at least one or more responsible parties.*

Emergency School Closing

Can your child be left alone? YES NO (please check one)

In case of an emergency school closing, list a person where your child would go (i.e. in neighborhood) in case you were not home. Listen to WCCO 830 AM Radio for school closings.

(Name) (Address) (Relationship to Student) (Phone)

Medical Emergency Information

Family Physician _____ Phone (____) _____

Clinic Name and Address _____ Fax (____) _____

List any medication allergy: _____
List any other allergy: (i.e. food type, pollen, bee stings) _____

In case of serious situation, I request the school district/bus company to contact me. If they are unable to reach me, I hereby authorize the school district/bus company to contact the emergency contacts above and to provide my child with transportation home or for medical treatment. In case of a serious, life threatening illness or accident, I request the school district/bus company to contact me and/or a physician to make whatever arrangements necessary for the safety of my child. The above information may be released to the transportation company driver and staff, in addition to the classroom teacher.

Parent/Guardian Signature _____ Date _____ / _____ / _____

For office use only:
Name of Staff Routing _____ Date _____ / _____ / _____
Please check off who was routed this form:
 Student file IEP manager 917 LSN Building Nurse Home District Transportation Bus driver Spec. Ed Vans