ANNUAL EMERGENCY INFORMATION RECORD

STUDENT LAST NAME	STUDENT FIRST NAME
GRADE/SCHOOL YEAR	DOB

MOTHER'S NAME & ADDRESS	MOTHER'S PHONE NUMBERS HOME: CELL: WORK:	MOTHER'S EMAIL ADDRESS
FATHER'S NAME & ADDRESS	FATHER'S PHONE NUMBERS HOME: CELL: WORK:	FATHER'S EMAIL ADDRESS

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE, CONTACT:

NAME:________________RELATIONSHIP:__________ HOME #:_____DAYTIME #:_____CELL #:_____

NAME:________________RELATIONSHIP:__________ HOME #:_____DAYTIME #:_____CELL #:_____

STUDENT'S PHYSICIAN	CLINIC	PHONE

ALLERGIES AND OTHER MEDICAL CONDITIONS: (Please explain checked item below or, if necessary, use other side of paper)

☐ ALLERGIES __________ ☐ ASTHMA __________ ☐ HEADACHES __________

☐ EPILEPSY __________ ☐ HEART PROBLEMS __________ ☐ ADD / ADHD __________

MEDICATIONS TAKEN AT HOME ____________________

CIRCLE IF YOUR CHILD WEARS THE FOLLOWING: GLASSES / CONTACTS / HEARING AIDS / PE TUBES

RESTRICTIONS: DIET / GYM / SPORTS/ ETC.: *(Explain)*____________________

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary. I will not hold the school district financially responsible for the emergency care and/or transportation for my child.

Your signature also indicates permission to share health information with appropriate medical, school, and other support staff (food & bus service), as necessary.

PARENT SIGNATURE:____________________**DATE:**__________

Has your child received any immunizations in the past year? If yes, please provide dates to the school. Please note if you have already done so.
List: ____________________

School Consent to Share Immunization Data – PLEASE READ & SIGN BELOW

MN law (M.S. 144.3351) requires that all students receive immunization to prevent the spread of infectious diseases. The Minnesota Immunization Information Connection (MIIC) collects immunization records from medical clinics, public health, and schools in order to help satisfy the requirements of this law. This information is used to help protect your child and prevent the spread of disease in your community. The information can only be shared with those entities allowed by MN law and the information can only be used for immunization record keeping.

The Federal Education Right to Privacy Act (FERPA) requires school to have parental/guardian consent for schools to share your child's immunization record with medical clinics, public health, and MIIC in order to satisfy the MN School Immunization Law. Your signature will authorize the School District to release your child's immunization records to your medical provider and to the immunization registry. This information can only be used to improve the quality and timeliness of immunization services and to help schools enforce the School Immunization Law.

☐ I do authorize ☐ I do not authorize

PARENT / GUARDIAN SIGNATURE: ____________________**DATE:**__________