Central Lutheran School
2009-10 Emergency Contact Information
(Fill out one form for each child enrolled)

Student Info:

_____ _____ _____
Last (legal name) First MI

_____ _____
Street Address /PO Box City/Zip

_____ ____/_____/_____ _____ _____
Home phone Birth date Age Grade for 09-10

Parent/Guardian Info:

_____ _____
Father's Name Mother's Name

_____ _____
Address and home phone *(if different from child)* Address and home phone *(if different from child)*

_____ _____
Employer Employer

_____ _____ _____ _____
Work phone Cell phone Work phone Cell phone

Who has legal and primary custody of child? _____

If shared custody, provide other parent's name: _____

Treaters:

Physician_____ Phone: _____

Dentist: _____ Phone:_____

Hospital Preference_____

Health Insurance Co:_____ Policy #_____

Permission To Treat:
In case of accident or serious illness, I request the school to contact me/us. If I/we cannot be reached, I/we authorize the school to make whatever arrangements it deems necessary to ensure the health and welfare of my/our child.

_____ ____/_____/_____
Signature of parent/guardian Date

Emergency Contacts: If parents/legal guardian are not available, I/we authorize the persons listed below to serve as emergency contacts for my/our child *(must provide at least 2 names):*

Name	**Relationship to child**	**Phone**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Important Health History:

No Yes

□ □ Allergies (list) _____

□ □ Regular Medications (list) _____

□ □ Chronic Illnesses (list)_____

Please list any other medical information the school may need to know:

_____

_____

_____

_____

Permission to Administer OTC medications:

School officials will administer OTC pain medications sparingly and only for an occasional headache or ailment. (We will not administer pain/fever reducers when the student exhibits a fever, as the student will be sent home.)

I give Central Lutheran School and any of its representatives permission to administer the following meds, according to package directions. My signature below absolves the school of any responsibility/legal remedy in the event the child suffers ill effects due to the administration of the following meds:

_____Tylenol (liquid/chewable OR swallow tablet—school will decide based on availability)
_____Advil (liquid/chewable OR swallow tablet—school will decide based on availability)
_____Tums/Rolaids/PeptoBismol

_____ _____/_____/_____

Parent signature **Date**

Fluoride Treatments:

If the Iowa Dept. of Public Health provides fluoride rinse (0.2% fluoride mouth rinse) for grades 1-8, I want my child to participate in the once-a-week program. (Check one)

_____ Yes, please administer fluoride.

_____ No, please exclude my child from the program.