

SYOSSET CENTRAL SCHOOL DISTRICT

Syosset, New York

STUDENT EMERGENCY INFORMATION

PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH OFFICE AS SOON AS POSSIBLE

Student's Name: _____ Sex: _____ Grade: _____

Date of Birth: _____ Place of Birth: _____

Parents'/Guardians' Name: _____
Last Name First Name

Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Name: _____
Last Name First Name

Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

If Parents/Guardians not available in emergency call: (This is also an authorization to release my child to the adults listed below.) Please inform persons listed below that their names appear as emergency contacts.

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

1. Has your child had any serious illness, injury or operation during the past year? Yes: _____ No: _____

Specify: _____

2. Has or does your child receive(d) any medication on a regular basis? Yes: _____ No: _____

Specify : _____

3. Does your child have asthma, diabetes, epilepsy, a heart or orthopedic condition? Yes: _____ No: _____

Specify: _____

4. Does your child have any allergies? Yes: _____ No: _____

Specify: _____

5. Does your child have any vision or hearing problems? Yes: _____ No: _____

Specify: _____

6. Do you have any other information which would help the school in a better understanding of your child?

7. Has your child received any immunizations, tests, or had a physical exam in the past year?

Yes: _____ No: _____ Specify with dates: _____

Date: _____
Parent/Guardian Signature

Please use reverse side for additional emergency names and numbers.

THIS IS OUR ONLY MEANS OF COMMUNICATING WITH YOU IN AN EMERGENCY DURING SCHOOL HOURS.