

STUDENT EMERGENCY INFORMATION & HEALTH HISTORY

SIS-F007

ANSON COUNTY SCHOOLS

School _____

Name of Student _____ Birth date _____

Home Phone _____ Alternate Phone number _____

Teacher/Grade _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

List two Emergency Contacts who can assume temporary care of your child if you cannot be reached.

1. Name _____ P hone _____

2. Name _____ Phone _____

In case of a medical emergency, injury or serious illness, I hereby authorize school personnel to contact 911.

Date _____ Parent/Guardian Signature _____

Doctor _____ Phone _____

Hospital Preference _____ Serious Health Condition _____

List any medications taken daily or medications needed in a medical emergency

Important Medical Information

Any medication needed at school? List: _____

Hospitalized or major health changes in the last year? _____

_____ Allergies (List) _____

Vision Problems _____

_____ Asthma

Hearing Problems _____

_____ Arthritis

Heart Problems _____

_____ Diabetes

Bleeding Problems _____

_____ Seizure/Date of Last Seizure _____

Orthopedic Problems _____

_____ Sickle Cell

Other _____