

**WYOMING VALLEY WEST SCHOOL DISTRICT  
EMERGENCY INFORMATION RECORD**

Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Birth Date \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone (Home) \_\_\_\_\_  
 \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Phone (Business) \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Phone (Business) \_\_\_\_\_  
 \_\_\_\_\_ Cell Phone \_\_\_\_\_

*Please indicate phone number that should be called first for immediate parent contact.*

Does your child have a Court Order/Affidavit that establishes custody? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, a copy must be provided to the school immediately. This must be submitted yearly.

Name of person willing to assume responsibility in your absence. (This person should be easily reached during school hours):

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

**I give the school authorities permission to take my child to the nearest hospital in case of serious accident or illness.**

Hospital Preference \_\_\_\_\_

*Please check  Does your child have any of the following conditions?*

- |   |  |
|---|--|
| <p>1. Is your child currently taking any medication daily? _____ Yes _____ No<br/>List medication _____</p> <p>2. <b>Diabetes</b> - _____ Yes _____ No<br/>Medication/type _____</p> <p>3. <b>Heart Condition</b> - _____ Yes _____ No<br/>Medication _____<br/>Restrictions _____</p> <p>4. <b>Epilepsy</b> - _____ Yes _____ No _____<br/>grand mal _____ petite mal _____ seizures _____<br/>Medication _____</p> <p>5. <b>Asthma</b> - _____ Yes _____ No<br/>Medication _____</p> <p>6. Does your child wear any appliances? (glasses, hearing aide, etc.)<br/>_____</p> | <p>7. <b>Allergy to bee sting</b>- _____ Yes _____ No<br/>reaction- _____ mild _____ severe<br/>Medication _____<br/>Special Instructions _____</p> <p>8. <b>Allergy to drugs</b> - _____ Yes _____ No<br/>(e.g. Penicillin, Aspirin, etc.) Please list medications and reactions.<br/>_____<br/>_____</p> <p>9. <b>List other allergies</b> _____<br/>reaction - _____ mild _____ severe<br/>Medication needed _____<br/>Special instructions _____</p> <p>10. List any special problem or restrictions<br/>_____<br/>_____</p> |
|---|--|

**By my signature below I give permission to share this information with appropriate staff when necessary.**

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

*Revised 07/2008*