

**Student Contact/Medical Information Update ESY Program 2019**

Student Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Circle: M/F  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ Room: \_\_\_\_\_

**Parent/Guardian Information:**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

**Emergency Contact Information:**

*The individuals below have authorization to pick up my child and can be reached during school hours at the numbers listed.*

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

**Health Information:**

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance: \_\_\_\_\_

Significant recent illnesses, accidents, operations and/or medical problems  
**(including asthma)**:  
\_\_\_\_\_

Current medicines (include over the counter medications/herbals used regularly):  
\_\_\_\_\_

Does your child have **life-threatening allergies/allergies** requiring medication in school? \_\_\_\_\_

Does your child need ANY medication given in school?  
\_\_\_\_\_

Does your child wear glasses, hearing aides or other type of prosthesis?  
\_\_\_\_\_

Are there any emotional concerns we should know about?  
\_\_\_\_\_

*I understand that all types of jewelry/piercings need to be removed for PE for the safety of my child AND others \_\_\_\_\_ (initial please)*

I give permission for health information to be shared with necessary personnel for the health and safety of my child.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*\*\*\*Please return with your ESY response form.\*\*\*\*\***