

**IT IS THE PARENT/GUARDIAN RESPONSIBILITY TO NOTIFY THE CENTRAL REGISTRAR AND/OR SCHOOL NURSE WHEN ANY CHANGES OCCUR**

Whitehall-Coplay School District  
**HEALTH EMERGENCY FORM**

**Student Name:**

Student ID#: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Student Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ Gender: \_\_\_\_\_  
Ethnicity: \_\_\_\_\_ Grade: \_\_\_\_\_

PLEASE ATTACH ALL DOCUMENTATION PERTAINING TO CONSEQUENCES OF LEGAL GUARDIANSHIP

***Mother Information:***

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell/Pager: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

***Father Information:***

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell/Pager: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

***Guardian Information:***

Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell/Pager: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
E-Mail: \_\_\_\_\_

Child lives with: \_\_\_\_\_

**Telephone Messaging system:**

Telephone #1 \_\_\_\_\_ Telephone #2 \_\_\_\_\_

**THE PARENT/GUARDIAN WILL BE CONTACTED FIRST UNLESS NOTED OTHERWISE**

***Emergency Contact Information:*** Please list all adults other than the parents/guardians in the order in which they should be contacted

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Please release my child to any of the persons listed above**

***Emergency & Health Information:***

Hospital \_\_\_\_\_ Phone \_\_\_\_\_  
Physician: \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone \_\_\_\_\_

Medical Alert:

Health & Emergency Comments: \_\_\_\_\_

Health Comments for Busing: \_\_\_\_\_

Above information will be shared with your child's teachers, coaches, transportation workers and food services employees for your child's welfare. In the event your child should become seriously ill or injured while at school and require prompt emergency care, do we have your permission to secure medical attention from the nearest source without incurring any financial obligation to the school if we are unable to immediately locate you (parent/guardian)?

**Epinephrine will be administered when symptoms of severe allergic reaction occurs.**

Please check one: YES \_\_\_\_\_ NO \_\_\_\_\_

Student Name: \_\_\_\_\_

Print Parent/Guardian Name (1): \_\_\_\_\_

Parent/Guardian Signature (1): \_\_\_\_\_ Date: \_\_\_\_\_

Print Parent/Guardian Name (2): \_\_\_\_\_

Parent/Guardian Signature (2): \_\_\_\_\_ Date: \_\_\_\_\_