School Year _____

Minnewaska Area Schools

Student Emergency, Medical and Contact Information

To better serve your student's needs, please complete all sections of this form for your child each school year. Check the SR box by all phone numbers and email addresses you would like to receive notifications for school-related announcements, closings, schedule changes and similar events.

STUDENT INFORMATION

Name _____ DOB_____ Grade _____ Sex: ☐ Male ■ Female

Who does the student reside with? _____ Relationship to Student _____

Student's Cell Phone Number _____ ☐ SR Student's Email _____ ☐ SR

PARENT/GUARDIAN CONTACT INFORMATION

Person 1 (Full Name) _____		Person 2 (Full Name) _____	
Home Phone _____	☐ SR	Home Phone _____	☐ SR
Cell Phone _____	☐ SR	Cell Phone _____	☐ SR
Email _____	☐ SR	Email _____	☐ SR
Work Place _____	☐ SR	Work Place _____	☐ SR
Work Phone _____	☐ SR	Work Phone _____	☐ SR

EMERGENCY CONTACT INFORMATION

This should be persons other than parent(s)/guardian(s). We will try to contact the parent(s)/guardian(s) before we use the emergency contacts unless we are instructed otherwise.

EMERGENCY CONTACT PERSON 1

Name _____ Phone_____

Relationship _____

EMERGENCY CONTACT PERSON 2

Name _____ Phone_____

Relationship _____

EMERGENCY MEDICAL INFORMATION

Physician _____ Physician Phone _____

Dentist _____ Dentist Phone _____

Do you have Medical Insurance or Medical Assistance? ■ Yes ☐ No

Name of Medical Insurance or Health Plan _____

Does your child have a medical condition that will require supervision or restrict their physical activity? ■ Yes ☐ No

If Yes, please explain

Does your child take medication/s? ☐ Yes ☐ No

If Yes, please explain (name of medication, dosage, time given, condition being treated)

School Year _____

Minnewaska Area Schools

Student Emergency, Medical and Contact Information

Note: Parent(s)/guardian(s) must supply and provide all medications (prescription or over-the counter) in the pharmacy/original container. If a student needs a medication in school, a proper authorization has to be in place prior to administration. Please refer to the school website: www.minnewaska.k12.mn.us/departments/health-services/ for more information and to obtain the required forms. You may also call the school at (320) 239-4820 to obtain the required medication form.

Has your child had any complaints of or been medically treated for any of the following? Please note approximate date, current treatment, and present condition. *If yes, please specify.

ALLERGIES	YES	NO
Food*	☐	☐
_____		
Medication*	☐	☐
_____		
Pollen/Hay fever	☐	☐
Animals/Bee Sting*	☐	☐
_____		
Severe Allergic Reaction*	☐	☐
_____		
Allergy Shots	☐	☐
Allergy Medication*	☐	☐
_____		
Asthma	☐	☐
Needs Asthma Inhaler in school?	☐	☐
Needs Epi-Pen at school?	☐	☐

PHYSICAL HEALTH	YES	NO
Chronic Disease/Illness*	☐	☐
_____		
Diabetes	☐	☐
Eyeglasses/Contacts	☐	☐
Hearing Loss	☐	☐
Heart Condition	☐	☐
Kidney Condition	☐	☐
Orthopedic Condition	☐	☐
Skin Condition	☐	☐
Broken Bones/History of Surgery*	☐	☐
_____		
Behavioral*	☐	☐
_____		
Seizure Disorder	☐	☐

ADDITIONAL HEALTH-RELATED CONCERNS

I, the undersigned parent/guardian, give my consent for the above named child to be released to me or my spouse or to the friend/relative I have so designated and/or to be taken by ambulance to the nearest hospital in case of emergency.

I understand that Minnewaska Area Schools does not provide accident medical/dental coverage for students for injuries/illnesses occurring at school.

I further acknowledge that I am financially responsible for medical, dental, ambulance, or other health care expenses or transportation of my child home, which might occur as a result of such illness or injury.

Signature Parent/Guardian _____ Date _____