The Hallen School
Emergency Contact Form
2024-2025

Today's Date: _____

Student:

Last Name *First Name* *Middle* *Date of Birth*

Home Address *City* *State* *Zip*

Mailing Address (if different from above)

Parent 1/ Guardian 1:

Last Name *First name* *Realtionship*

Address (if diffent from above) *Phone: cell, work, home*

Email Address *Phone: cell, work, home*

Parent 2/ Guardian 2:

Last Name *First name* *Realtionship*

Address (if diffent from above) *Phone: cell, work, home*

Email Address *Phone: cell, work, home*

Student lives with: Please list above

Authorized Contacts: Please list the names of authorized contacts that we may release your child to or contact if you cannot be reached in an emergency. **No student will be released to anyone other than the parent/guardian or individuals listed on the form.**

	Name	Relationship	Daytime Phone	Can Pick Up?
1				Yes No
2				Yes No
3				Yes No

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation, or emergency that may occur while student is in school. I declare that the information on this form is true and correct. I will notify the school immediately of any and all changes.

Signature of Parent or Guardian *Date*

Annual Medical Update

Does the student have any condition or health issue that may affect participation in any physical activity?

Yes / No If yes please explain: _____

Medical Conditions: _____

Does the student take medications? Yes / No If yes please list below:

Medication Name	Dosage	Takes at Home or School?	Time taken everyday or is it the medication taken as needed?

If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. A current medication administration form must be filled out by the student's physician and kept on file in the nurse's office to dispense medication. STUDENTS CANNOT CARRY THEIR OWN MEDICATION UNLESS THE PHYSICIAN HAS DEEMED THE STUDENT INDEPENDENT CARRY FOR AN INHALER.

Allergies: Yes / No

If yes, please list: _____

Does the student take medication for severe allergic reactions? Yes / NO

If yes, please list the medication: _____

Asthma: Yes / No

Does the student use an inhaler? Yes / No Does the student use a nebulizer? Yes / No

Diabetes: Yes / No

Takes insulin? Yes / No Takes an oral medication? Yes / No Restrict Sweets? Yes / No

Seizure Disorder: Yes / No

Takes daily medication? Yes / No Has a rescue medication? Yes / No

Vision Problems: Yes / No Wears glasses? Yes / No Wears contacts? Yes / No

Hearing Problems: Yes / No Wears hearing aid? Yes / No

Emergency Treatment Authorization

In the event of an emergency, I request the school contact me, if they are not able to reach me and emergency care is considered necessary, I give permission to the school to seek emergency medical care, including transportation to and care at the closest emergency facility and I assume financial responsibility for such. I give permission to the school nurse / counselor / principal to contact my child's medical or dental care providers for the purpose of sharing or requesting pertinent information to my child's health and care or treatment received.

_____

Signature of Parent or Guardian *Date*