Frontier Junior/Senior High School
Emergency Information Form

At the beginning of each school year, an Emergency & Medical Information forms needs to be completed for each student who will be attending Frontier Junior/Senior High School. The information on this form is very important when the school must contact a parent when a need arises for the student.

Please **print** the information below.

Student's Name: _____ Grade Level: _____

Parents/Guardians Names: _____
(who the student lives with)

Address: P.O. Box_____ Street/Road Address: _____

City: _____ Zip Code: _____

Please list area codes for all phone numbers listed on this sheet.

Home Phone #: ( )_____ Students Cell: ( )_____

Father's Work Phone Number: ( )_____ Cell Phone: ( )_____

Mother's Work Phone Number: ( ) _____ Cell Phone: ( )_____

Father's Email:_____ Mother's Email:_____

If you wish to receive the school newsletter via email please check here: _____Yes _____No

Contact Information

Please provide the names of those individuals who may be contacted in regards to your student in case of an emergency. Be sure to list family, friends, and/or neighbors, etc. who may be contacted if your student is sick or injured**.**

If a person is not listed on this form, we *will not* release your student to them.

First Contact Person: _____ Day Number: ( )_____
Relationship to student: _____

Second Contact Person: _____Day Number: ( )_____
Relationship to student: _____

Third Contact Person: _____ Day Number: ( )_____
Relationship to student: _____

Fourth Contact Person: _____ Day Number: ( )_____
Relationship to student: _____

Fifth Contact Person: _____ Day Number: ( )_____
Relationship to student: _____

Parent/Guardian Signature: _____ Date_____

Revised: 5/27/09

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Frontier Junior/Senior High School
Medical Information Form

Student's Name: _____ Grade_____

Is student covered by parent's/guardian's insurance? Yes No (Circle one)
If yes, Name of Insurance Company _____Policy Number_____
Insured Name (Parent/Guardian) _____

Health History: (check)
_____Diabetes
_____Epilepsy
_____Cardiac Problems
_____Concussions What year? _____
_____Date of Last Tetanus Booster

Allergies: (check)
_____Aspirin allergy
_____Penicillin allergy
_____Sulfa allergy
_____Insect Stings - Insect _____
_____Tetracycline allergy
_____Other Medication allergies _____

Orthopedic Problems (known bone, joint, or muscle injury) _____

_____

Known Allergies_____

_____

Asthmatic_____, if so, what medication(s) do you use: _____

Please list any medications that your student takes on a regular basis _____

_____

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity or from participating in any activities? If yes, please explain. Mention any recent illness, injuries, allergies (other than drugs) or other physical condition that we should be aware of before treating your child.

_____

_____

Doctor_____ Phone ( )_____

Dentist_____ _____ Phone ( )_____

Hospital Preference_____

Parent's Authorization: This health history is correct to the best of my knowledge, and the student herein described has permission to engage in all activities, unless noted by me. I give permission to the physician, trainer, coach, faculty/staff member, or hospital selected by a representative of my son/daughter's school to hospitalize and secure proper treatment for my child as named above. I also authorize the physician, athletic trainer, coach, faculty/staff member to exchange information relating to the medical care of my child. Any health care provider involved in care of the above named athlete is authorized to supply the physician, trainer, coach, faculty members with medical records, verbal discussion, and written summaries as needed to facilitate the student's care and safe return to activity. This authorization is ongoing through the entire school year.

Parent/Guardian Signature_____ Date_____

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