Brockton Public Schools
Confidential Student Emergency Information Form

Date______________________

Grade_______ Room________

Student's Name____ Birth Date___________________

Last First Middle

Place of Birth_____________________

Address____ Brockton, MA 0230___ Home Tel. ( ) _________________

Emergencies such as a sudden illness or accident often occur at school. In the event of an emergency, your child will be transported to the nearest local hospital.

Please complete the following information:

______________________________ ____________________________ _________________ ________
Mother's/Guardian's Name Address City/Town Zip

______________________________ ____________________________ _________________ ________
Father's/Guardian's Name Address City/Town Zip

Child lives with Both ( ) Father ( ) Mother ( ) Guardian ( )

Mother's/Guardian's Occupation ____________________ Place of Employment_______________________________________

Address____ City/Town ___________________ Tel. ( ) _______________

Father's /Guardian's Occupation ____________________ Place of Employment_______________________________________

Address____ City/Town ___________________ Tel. ( ) _______________

Please arrange for **two other** responsible adults to care for your child in the event that you cannot be reached.

Name__________________________________ Address____

City/Town ______________________________ Tel. ( ) ________________

Name__________________________________ Address____

City/Town ______________________________ Tel. ( ) ________________

Please indicate if there are any parental restrictions (e.g., current retraining order)

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Please indicate if your child has had Chicken pox ___ German measles ___ Tuberculosis ___

Please indicate if your child wears Hearing aid(s) ___ Glasses ___ Dentures or partial plates ___

List any **medications**, or **chronic health conditions** such as eye or ear problems, heart disease, diabetes, asthma, allergies*, seizure disorder, etc.

Explanation ____

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***Indicate all allergies** (be specific)

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Physician's Name_____________________ Address__________________________________ Tel. ( ) _____________

Dentist's Name______________________ Address__________________________________ Tel. ( ) _____________

Health Insurance____ Policy Number ___________________________

Group Number_________________________________

Has your child had a physical exam within last two years __ yes __no Date________________________

Last dental visit Date_________________

I give permission for the School Nurse to share medical information with the appropriate school personnel and to contact my child's physician as necessary.

Signature of Parent/Guardian____ Date_________________

List other children living in the home.

Name	Date of Birth	Name of School

If you have no health insurance, the Commonwealth of Massachusetts has a health insurance plan that will provide uninsured children with affordable health care (restrictions may apply). If you are interested in more information about this program, please contact the School Nurse.

Copies: Main Office (original) School Nurse (yellow) and Homeroom Teacher (pink) Effective date 6/30/02