REQUIRED EMERGENCY/OFFICE INFORMATION
Jackson County Central Schools 2013 - 2014

STUDENT Legal/ Birth Name: First ________________________ Middle_______________ Last ___________________________

Grade__________________________ Birth date: ____________________ Social Security #_______________________________

Physical Address____

Mailing Address ____ Home Phone __________________________________

City _________________________St ____________Zip_______________

*Have you ever attended a MN Public School?________ If yes, please list LAST District attended_________________

Are you Hispanic/Latino? ____ No, Not Hispanic/Latino
____ Yes (A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.)

What is your race? (Choose one or more) **Primary Home Language ________________________**

____ American Indian or Alaska Native
____ Asian (Far East, Southeast Asia, Indian Subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, Vietnam; examples)
____ Black or African American
____ Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa; examples)
____ White

MOTHER Name___________________________________
Mailing Address___________________________________
Physical Address__________________________________
MOTHER Work Place______________________________
MOTHER Work Phone_____________________________
MOTHER Cell____________________________________
MOTHER e-mail__________________________________

FATHER Name____
Mailing Address____
Physical Address ____
FATHER Work Place_______________________________________
FATHER Work Phone______________________________________
FATHER Cell____
FATHER e-mail ____

PERSON AUTHORIZED to remove child from school:____

PERSONS NOT AUTHORIZED to remove child from school:____

If we need to contact you for a Non-Emergent question or concern, how do you prefer to have us contact you? (Complete One)

Email ____or Phone ____

JCC HEALTH HISTORY **Please provide the following information for the health office:**

Student Name: ____ Birthday: ____/____/______ Grade:______
Family Doctor: ____ Clinic: ________________________________

*Please circle if your child has been diagnosed with any of the following:

Asthma	**Food allergy**	**Depression**	**Learning Disability**
Cardiac Condition	**Seasonal Allergies**	**ADD/ADHD**	**Developmental Delay**
Diabetes	**Other Allergy**	**Gastrointestinal Disorder**	**Anxiety**
Cancer	**Seizure Disorder**	**Other Mental Health Diagnosis**	

Please explain any of the above if necessary: ____

____

*Will your child have an **Epi-Pen** in school for ANY allergy? Yes No If yes, for which allergy? ___________________

*Does your child wear contacts or glasses? Yes No

*Does your child have a hearing impairment? Yes No If yes, does he/she have hearing aids? Yes No

*Please list any major medical condition and/or surgery that your child has/had: __________________________________

____

*Please list all medications your child takes (include over- the-counter medications): _______________________________

____

*Please list any other specialty care or mental/emotional care that we should be aware of: _________________________

____

*Additional Information: ____

____

*** **Reminder** - The following forms need to be completed by a healthcare professional:

A Special Diet Statement for the kitchen to provide food substitutions for food allergies.
An Asthma Action Plan for students with asthma (required for students with inhalers at school).
An Allergy Action Plan for students with severe allergies.

Emergency or Illness

In case of an injury or illness, please list contacts ***in the order we should attempt calling, including parents/guardian***. Please include at least one person that does not live in the same household.

	Name	**Relationship**	**Phone Number/s (indicate work, cell, home)**
1.			
2.			
3.			
4.			

In case of an emergency, staff will notify the first person we are able to contact from the list above. When that is not possible or the situation is emergent:

1. School personnel may transport your child to the Sanford Clinic in Lakefield or Jackson, or the Sanford Jackson Medical Center emergency room.
2. 911 may be called to take your child to the nearest emergency room they determine to be appropriate.

Signature of parent/guardian: ____ Date:______________________