SOUTH EUCLID-LYNDHURST CITY SCHOOLS
Written Emergency Information
Preschool

Student Information

First Name ______
Middle Name ______
Last Name ______
Suffix (Jr. etc.) ______
Grade: Preschool
School: Rowland
Date of Birth ______
Primary Phone ______

Student's Residential Address

Address ______
Apt. # ______
City ______
State ______
Zip Code ______

Family Information – Primary Contact – Must live with student

Title: ______
First Name: ______
Middle Name: ______
Last Name: ______
Relationship: ______
Home Phone: ______
Cell Phone: ______
E-mail Address: ______
Employer: ______
Occupation: ______
Work Phone ______ Ext ______
Work E-Mail ______
Primary Language ______
Willing to Volunteer? Yes No

Emergency Contacts are the only people who may sign out your child in the event of an emergency

Emergency Contact 1

First Name ______
Last Name ______
Relationship to student ______
Home Phone ______
Cell Phone ______
Work Phone ______

Emergency Contact 2

First Name ______
Last Name ______
Relationship to student ______
Home Phone ______
Cell Phone ______
Work Phone ______ EXT ______

Emergency Contact 3

First Name ______
Last Name ______
Relationship to student ______
Home Phone ______
Cell Phone ______
Work Phone ______ EXT ______

Family Information – Copied on Correspondence

Title ______
First ______
Middle Name ______
Last Name ______
Relationship ______
Does this parent live with the student? Yes No
Home Phone ______
Cell Phone ______
E-Mail Address ______
Employer ______
Occupation ______
Work Phone ______ EXT ______
Work e-mail ______
Primary Language ______
Willing to volunteer? Yes No

Emergency Medical Consent: in the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

Emergency Medical Contacts

I hereby give consent for the following medical care providers and local hospital to be called. **Yes** **No**

Physician Name ______
Phone ______
Dentist Name ______
Phone ______
Eye Specialist ______
Phone ______
Other medical specialist ______
Name ______
Specialty ______
Phone ______
Local Hospital ______
Phone ______

In case of emergency, do you give Emergency Medical Consent for the medical treatment of your child? ☐ **Yes** ☐ **No**

Allergies

Food Allergies Yes No
What food(s) ______
Bee Sting Allergy Yes No
Other Allergies (Please list) ______

Medications

Does your child take medications? Yes No
Name of drug(s) ______
Will your child need to take medications during school? Yes No
What medication? ______