ID#_____

Charlotte-Mecklenburg Schools
EMERGENCY LOCATION AND HEALTH SURVEY CARD

5120.5A | Rev. 4/12

Bus#_____

Student's Last Name | First Name | Middle Name

Grade | Birthdate | Social Security Number

Student's Home Address | Zip Code | Home Phone | Teacher/Homeroom Teacher

Father/Guardian Name | Place of Business or Work | Phone | Cell Phone

Mother/Guardian Name | Place of Business or Work | Phone | Cell Phone

If one parent is to be contacted first or second please put #1 & #2 next to each parent's name.

Home /Primary Email address: _____

In case of Illness or Emergency, the following person(s) may be contacted if the parents/guardians cannot be located:

Name of Friend/Neighbor/Relative | Phone Number | Preferred Hospital/Phone Number

If my child is in an accident or becomes sick and cannot remain in school, I understand that the parent/guardian will be notified immediately. If they cannot be contacted, the neighbor or friend listed on this card will be contacted. If the accident or illness is not an emergency and emergency contacts are unable to pick up the child then he/she will remain at school until the parent/guardian can be contacted. I further understand that if the child is too ill to ride the bus that the parent must make arrangements to get the child home.

In the event that it becomes apparent that the child needs immediate medical attention and the parents or emergency contact cannot be reached, the school principal (or designee) has my permission to send the child to an emergency room by EMS. I understand that I will bear the financial responsibility for transportation and treatment. Medical information may be shared with school personnel who need to know in order to provide for the health and care of my child.

I give the school/nurse my permission to share my child's shot records with the North Carolina Immunization Registry and/or a provider who needs it when giving my child immunizations. ☐ Yes ☐ No

Signature of Parent/Guardian: _____ **Date:** _____

Please list any health concerns on the back side of this card.

- OVER-

For your child's safety, medical information may be shared with appropriate school staff on a need to know basis in your child's school. Does your child/student have any of these conditions listed below? If so please place a check mark next to any health condition your child has.

____Food Allergy	____ADD/ADHD	____Cancer	____Seizures	____Asthma (please check below)
____Insect Allergy	____Bone/Muscle Problem	____Sickle Cell Disease	____Bladder/urinary problems	____Daily meds for asthma
____Seasonal Allergy	____Diabetes	____Hearing Loss	____Kidney Disease	____Inhaler at school
____Other Allergy	____Hemophilia	____Heart Trouble	____Bowel problems	____Last asthma episode
____Vision Trouble	____Activity Restrictions	____High Blood Pressure		

____Other Specify Other:_____

____ Has your child had any overnight hospital visits in past 12 months?_____ For what?_____

____ER visits in the past 12 months? For what?_____

Describe special needs the student has that are associated with physical, emotional, mental, or behavioral conditions (for example: needs frequent bathroom breaks, carries Epi-Pen, or uses wheel chair):_____

_____

Insurance Provider:_____ HMO:_____

Insurance #:_____ Medicaid #_____

Regarding Medications at School:

A medication authorization form must be completed by the doctor and parent in order for any medication to be given at school. This includes prescription OR over-the-counter medication such as Tylenol, cold medicines, or ointments. The completed medication authorization form is also required for any student who desires to self carry their medication while at school. Authorization forms may be obtained at your child's school.

Note: The school nurse can be contacted through the school office if additional information needs to be provided, or consultation is needed during the school year.

Comments: _____

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