

- ALLERGIES  
 ASTHMA  
 DIABETIC

## 2009-2010 CMCS SECONDARY CAMPUS EMERGENCY INFORMATION

For  
Office  
Use

STUDENT LAST NAME			FIRST NAME				MIDDLE INITIAL					
HOME PHONE (        )						GRADE						
HOME ADDRESS			CITY		STATE		ZIP					
SEX		BIRTH DATE			STUDENT CELL #							
NAME OF PERSON(S) WITH WHOM CHILD LIVES/RELATIONSHIP				E-MAIL ADDRESS								
LEGAL MOTHER'S NAME			ADDRESS (IF DIFFERENT THAN CHILD'S)									
HOME # (        )		WORK # (        )			CELL # (        )							
LEGAL FATHER'S NAME			ADDRESS (IF DIFFERENT THAN CHILD'S)									
HOME # (        )		WORK # (        )			CELL # (        )							
<b>ADDITIONAL PERSONS WHO MAY BE CALLED IN AN EMERGENCY</b>												
PLEASE COMPLETE THE INFORMATION BELOW FOR PERSONS, OTHER THAN A PARENT, WHOM YOU AUTHORIZE TO PICKUP YOUR CHILD FROM SCHOOL. IF YOUR CHILD BECOMES ILL AT SCHOOL, AND WE ARE UNABLE TO CONTACT YOU, WE WILL CONTACT THE INDIVIDUALS YOU HAVE LISTED BELOW, IN THE ORDER LISTED. STUDENTS WILL NOT BE RELEASED TO INDIVIDUALS WHO ARE NOT LISTED ON THIS FORM.												
NAME		RELATIONSHIP			PHONE #		CELL #					
1.					(        )		(        )					
2.					(        )		(        )					
3.					(        )		(        )					
LIST INDIVIDUALS TO WHOM YOUR CHILD MAY NOT BE RELEASED UNDER LEGAL CUSTODY PROVISIONS (LEGAL DOCUMENTS MUST BE ON FILE IN THE SCHOOL OFFICE).												
1.		2.			3.							
<b>I AUTHORIZE CMCS TO DISPENSE THE FOLLOWING MEDICATION</b>			<b>TYLENOL</b>		<b>MOTRIN</b>		<b>TUMS</b>		<b>COUGH DROPS</b>		<b>BENADRYL</b>	
			Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
ALL PRESCRIPTION MEDICATIONS REQUIRE A DOCTOR'S NOTE AND PARENT CONSENT FORM AND MUST BE DISPENSED THROUGH THE SCHOOL OFFICE. IF A PHYSICIAN NEEDS TO BE CONSULTED AND NEITHER PARENT/GUARDIAN CAN BE REACHED, YOUR SIGNATURE BELOW AUTHORIZES CMCS TO TAKE YOUR CHILD TO A LOCAL PHYSICIAN OR CONTACT THE PHYSICIAN THAT YOU HAVE LISTED, TO RENDER NECESSARY TREATMENT (AT YOUR EXPENSE). IN THE EVENT OF AN EMERGENCY, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL AND CMCS WILL BE HELD HARMLESS IN ALL DECISIONS.												
NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN						HOSPITAL PREFERENCE			TYPE OF INSURANCE/POLICY #			
<b>PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOUR CHILD</b>												
NO KNOWN PROBLEMS				VISION PROBLEMS - IF SO, DOES CHILD WEAR CONTACTS OR GLASSES?								
ALLERGY - POLLEN/DUST/HAY FEVER				HEARING LOSS - IS SO, WHICH EAR?								
ASTHMA - NO MEDICATION REQUIRED				ADD/ADHD - IF SO, IS MEDICATION TAKEN?								
ASTHMA - REQUIRES MEDICATION				MIGRAINES - IS MEDICATION TAKEN?								
BLOOD DISORDER				DIABETIC - IF SO, DID YOU PROVIDE SCHOOL WITH DIABETIC KIT?								
CANCER/LEUKEMIA				ALLERGIC TO BEE STING								
CEREBRAL PALSY				ALLERGIC TO THE FOLLOWING FOOD(S)								
HEMOPHILIA												
SPEECH PROBLEM				ALLERGIC TO THE FOLLOWING MEDICATION(S)								
EPILEPSY/SEIZURES												
NAME OF SIBLINGS THAT ATTEND CMCS												
1)				2)				3)				
MISCELLANEOUS INFORMATION												
BY SIGNING THIS CARD, I AGREE TO HOLD CMCS AND ITS EMPLOYEES HARMLESS FROM ALL LIABILITY OR CLAIMS WHICH MIGHT ARISE OUT OF THESE ARRANGEMENTS. PLEASE NOTIFY THE SCHOOL OFFICE WHENEVER ANY OF THIS INFORMATION CHANGES.												
PARENT SIGNATURE									DATE			