



Lake Forest School District 67

New Student Emergency Contact Form

Student Name (Last, First, Middle): _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Birth Date: _____

Child Lives With (relationship: mother and father, mother, father, mother and stepfather, etc.): _____

Parent/Guardian Name: Dr. Mr. Mrs. Ms. _____

Employer & Address: _____ Phone: (____) _____

Cell Phone: _____ Pager: _____

Parent/Guardian Name: Dr. Mr. Mrs. Ms. _____

Employer & Address: _____ Phone: (____) _____

Cell Phone: _____ Pager: _____

Name of Person to Contact First: _____

Name of Family Physician or Pediatrician: _____

(Address) _____

(Telephone) _____

Name of Dentist: _____

(Telephone) _____

Name of Orthodontist: _____

(Telephone) _____

In case of an accident or sudden illness to your child while at school, **and we are unable to contact you**, whom do you wish us to notify? (Local, please.)

(Name)	(Address)	(Phone)	(Relationship)
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(Name)	(Address)	(Phone)	(Relationship)
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If, in the judgment of school authorities, emergency medical treatment is needed and I cannot be reached, I authorize the school to secure immediate emergency medical treatment.

Date: _____ Grade: _____

School: _____ Teacher: _____

Parent/Guardian Signature

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Student Health History

Name: _____ Grade: _____ Year: _____

ALLERGIES	NO	YES	EXPLANATION (please be specific)
Drugs			
Foods			
Environmental/Seasonal			
Insect bite/sting			
Other			
CHRONIC OR RECURRING CONDITIONS	NO	YES	EXPLANATION (please be specific)
ADD/ADHD/Autism Spectrum			
Asthma			
Cardiac			
Diabetes			
Emotional/Behavioral Disorders			
Genetic Disorders			
Headaches			
Orthopedic			
Seizure			
Other			
Does your child have a diagnosed hearing loss?			
Does your child wear glasses or contacts?			
Has your child ever been hospitalized?			

What medications has your child taken in the past year?

What medication is your child currently taking?

Lake Forest School District 67 respects the sensitivity and legally protected confidentiality of student health information. Your signature below allows this information to be shared with faculty/staff who need to know for the health, safety, and learning needs of your child. In the event of a medical emergency, a copy of this form may also be provided to the Emergency Medical personnel caring for your child.

Parent Signature: _____ Date: _____