Rochester School District Medical Authorization & Student Household Contact Form

Elementary

Please **PRINT** Neatly

Grade:_____
Teacher:_____
Bus# _____ Walk___ Car___

Student's Legal Name: _____ **Date of Birth**: ____/____/_____
Last First Middle MM DD YYYY

Gender (Circle One): Male / Female **Nickname** (Optional):_____

Address Where Student is Living: _____ **Apt #** (If Applicable) _____
Number Street City State Zip

Mailing Address (if different)_____ **Apt #** (If Applicable) _____
Number Street City State Zip

Parent/ Legal Guardian who student lives with: **Home Ph#**_____

Name: _____
Last **First** **Middle** **Relationship** **Cell Ph#** **Work Ph#**

Name: _____
Last **First** **Middle** **Relationship** **Cell Ph#** **Work Ph#**

Address: _____ **Apt #** (If Applicable) _____
Number Street City State Zip

Parent E-Mail Address: _____

Parent/ Legal Guardian who student does not live with (if applicable): **Home Ph#**_____

Name: _____
Last **First** **Middle** **Relationship** **Cell Ph#** **Work Ph#**

Name: _____
Last **First** **Middle** **Relationship** **Cell Ph#** **Work Ph#**

Address: _____ **Apt #** (If Applicable) _____
Number Street City State Zip

Parent E-Mail Address: _____

Emergency and Dismissal Contact

Please list two readily available people you would like for us to have on file related to your child who will assume temporary care of your child if you cannot be reached first or permission to dismiss.

1. _____ _____ _____ _____ _____
Last First M Gender Relationship to the student Phone Number #1 Phone Number #2

2. _____ _____ _____ _____ _____
Last First M Gender Relationship to the student Phone Number #1 Phone Number #2

Medical Information

Signing this form authorizes Frisbie Memorial Hospital to provide a free dental screening to your child. This will be done by a Registered Dental Hygienist and given to all students **grades 1-3**. This also authorizes Frisbie's Dental Program to release screening results for the purpose of follow up care to a dental professional when needed.

Check here for refusal ONLY____ Allergy to metal ____yes ____no. Allergy to Latex ___yes ____no

In case of an accident or serious illness and I cannot be reached, I hereby authorize the school personnel to secure medical help for my child.

Name of Student's Physician:_____**Tel.#**_____

Please list any health conditions/treatments including allergies (be specific), medications, chronic health conditions (asthma, seizures, etc.), glasses/vision concerns, hearing concerns, significant injuries etc. This information may be shared with those people who work with your child. If you have other confidential information you do not wish to list here but may affect your child's health care, please contact your child's school nurse.

_____

_____

Parent/Guardian Signature_____ **Date**_____

****Special circumstance – Please attach current legal documentation/information (custody issues, history, family circumstances, ect.)**

2016-17