Print Reset Save

# DR. GERTRUDE M. BAILEY INTERNATIONAL SCHOOL
# EMERGENCY INFORMATION FORM

LAST NAME | FIRST NAME | GRADE | ROOM # | TEACHER

Legal Name of Child _____

Date of Birth _____ ☐ Male ☐ Female Language Spoken at Home _____

Address _____ Zip Code _____ Home Phone: _____

Parent or Guardian #1 _____
☐ Custodial Parent Name Cell Phone

_____
Work Phone Email Address

Parent or Guardian #2 _____
☐ Custodial Parent Name Cell Phone

_____
Work Phone Email Address

Does your child have siblings at the Bailey? ☐ Yes, names:_____
☐ No

**Transportation:**

Does your child arrive at school by bus? ☐ Yes, bus number _____ ☐ No

How does your child leave school at dismissal?

☐ By bus number _____ ☐ Walking ☐ CTI Bailey School site ☐ Other:_____

**Emergency Contacts:**

In case of emergency, illness or accident, if the parent or guardian cannot be reached, these emergency contacts are authorized to pick up or assist my child:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

**Permissions:**

In case of medical emergency, does the school have your permission to take your child to the nearest hospital? ..... ☐ Yes ☐ No

Do we have permission to serve your child food (ice cream, popsicles, pizza) as related to school activities? ..... ☐ Yes ☐ No

Do we have your permission to take your child on field trips (by bus or on foot)? ..... ☐ Yes ☐ No

Do we have your permission to videotape/photograph/interview your child during special activities and events that take place in school? ..... ☐ Yes ☐ No

Does the school social worker have permission to speak with your child, if necessary? ..... ☐ Yes ☐ No

Signature of Parent or Guardian _____ Date _____

# Lowell Public Schools

**MEDICAL EMERGENCY FORM**

*Please Print:*

Student: _____ Date of Birth: _____ Gender : M/ F Grade: _____

Address _____

Parent/Guardian _____ Home Phone# (978) _____

Mother's work # _____ Mother's Cell Phone# _____

Father's work # _____ Father's Cell Phone# _____

Student's Physician_____ Telephone # _____

**List 3 local adults (other than parent/guardian) who will assume immediate care of your child and pick up your child at school in the event of illness or emergency:**

Name:_____ Tel: _____

Name: _____ Tel: _____

Name: _____ Tel: _____

Circle **all** current or active health conditions that apply to your child:

ADD ADHD Anxiety Asthma Autism/PDD Cerebral Palsy Depression Diabetes Heart Condition

Lactose Intolerance Migraines Seizure Disorder OTHER (please list)
_____

Vision Problems (specify) glasses ____ contacts _____

Hearing Problems (specify) Left ____ Right ____ Hearing aids: Left ____ Right____

Allergies (please list) _____

Is your child prescribed an **Epi pen** for treatment of the allergy listed above? Yes No

List medication and dosage taken by your child on a regular basis or as needed: _____

_____

Does your child have health insurance? Yes No MassHealth ? Yes No

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel as needed to meet my child's health and safety needs.

In case of emergency, your child will be transported to the hospital by EMS.

I hereby authorize the school nurse to contact my child's physician if necessary.

Signature of Parent/Guardian _____ Date _____