Mission Hills School

Emergency Information

Student Name: ____ Grade: __________
Last First

Address: ____

City: ______________________________ State: __________ Zip: ______________

Home Telephone: __________________________ Birthdate: ______________________

Where can parent/guardian be reached if not at home?

Parent 1: ____
First Name Last Name Work # Cell #

Email: ____

Parent 2: ____
Frist Name Last Name Work # Cell #

Parent 2 email: ____

List of persons authorized to pick up my child:

Name: ______________________ Phone: ________________ Relationship: __________

Name: ______________________ Phone: ________________ Relationship: __________

Name: ______________________ Phone: ________________ Relationship: __________

Name: ______________________ Phone: ________________ Relationship: __________

Disaster Release Authorization

If a parent/guardian is unable to pick up our child, I/we designate the following three people to whom our child may be released in case of an emergency.

LAST NAME	FIRST NAME	CELL PHONE	HOME PHONE	WORK PHONE

RELEASE STATEMENT: I authorize the release of my student to any adult designated above.

____
Signature of Parent/Guardian

SCHOOL USE ONLY

This student was released to: ______________________ Released by: ______________________

______________________________ ______________ ______________ AM PM
Signature (Person student was released to) Date Time

DESTINATION: ____

Health & Allergy Form

Child's name: _____ DOB: _____ M / F Grade:_____

If your child requires medication at school, a medication administration form must be completed.

____ Asthma (Please provide an Inhaler & complete Medication Administration Form)

____ Seizure (Please provide Doctor's instructions to follow in case of seizure)

____ Diabetes (Please provide Insulin, if needed & complete Medication Administration Form)

____ Allergies (Please provide EPI pen & complete Medication Administration Form):

☐ Nuts ☐ Latex ☐ Eggs ☐ Strawberries
☐ Ibuprofen ☐ Bee Sting ☐ other: _____

Are activities restricted? ☐ Yes ☐ No If yes, explain: _____

Medications taken/given at home (please list name and dosage of any medication(s) your child is taking:

Name: _____ Dosage: _____ Name: _____ Dosage: _____
Name: _____ Dosage: _____ Name: _____ Dosage: _____

Currently under a physician's care? ☐ Yes ☐ No Doctor: _____ PH: _____

For what reason: _____

Parental authorization

I hereby give my consent to MHMS to receive from or send to Dr. _____/Health Care Provider any information concerning my child.

Parent's signature: _____ Date: _____

Office use:

Date received: _____ Revised: 07/8/2019