



Teacher Name

Grade

STUDENT INFORMATION

Sex: Male, Female

Last Name, First Name, Middle Name, DOB

911 Physical Address, City, State, ZIP, Home Phone

Mailing Address, City, State, ZIP

Parent 1/Guardian Name, Home Phone, Work Phone, Cell Phone

Parent 2/Guardian Name, Home Phone, Work Phone, Cell Phone

1. Please list at least two relatives/friends and their phone numbers who will care for your child if you cannot be reached.

Print Name, Phone

Print Name, Phone

2. Does your child have siblings in the Pickens County School District? If so, please list:

3. If there are restrictions on who MAY NOT pick up your child, please list:

MEDICAL INFORMATION

1. If your child has a life threatening allergy or food related disability, please provide a written statement from a physician, along with a list of prescribed foods.

2. Please list any information (allergies, daily medicines, childhood diseases, etc.) pertinent for the care of your child while at school. If your child is allergic to bites or stings, please list and describe necessary treatment.

3. If you would like your child to have any of the following medications, please check below:

- Tylenol, Neosporin Ointment, Tums, Benadryl, Orajel, Advil, Hydrocortisone Cream, Peroxide, Cough Drops

4. I give the Pickens County School District permission to conduct a Hearing and Vision screening on my child: Yes, No

STUDENT'S PHYSICAL HISTORY

1. Please check all that apply:

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Handicap	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Otitis Media	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Speech Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	T.B. Contact	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Illness-Serious	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2. Has your child had Chickenpox? Yes No If yes, what year? _____

3. Has your child had Serious Injuries? Yes No If yes, what type? _____

4. Has your child had any operations? Yes No If yes, what type? _____

5. Does your child have seizures? Yes No

6. Does your child take medication that is to be given at school? Yes No
If yes, what type? _____

7. Does your child take medication on a daily basis at home? Yes No
If yes, what type? _____

CURRENT HEALTH INSURANCE INFORMATION

_____	_____	_____
Company	ID	Name of Insured
_____	_____	_____
Name of Physician	Physician Phone	

EMERGENCY TRANSPORTATION/TREATMENT RELEASE

Student Name

In the event that I cannot be reached in an emergency situation, I give permission for the above named student to be transported to the first available hospital and authorize the hospital to provide emergency medical or surgical treatment. I will assume full responsibility for all charges related to the above and release the hospital, the school and school system, its agents, employees, administrators and assigns from any and all liability, claims, and causes of action arising in connection with the transportation and/or treatment of the student named hereon.

Yes No

SIGNATURE

I have read the above and acknowledge all information provided on this form as being true and correct to the best of my knowledge.

X	X	_____
Print Name of Parent/Guardian	Signature of Parent/Guardian	Date