



PEABODY PUBLIC SCHOOLS

SCHOOL EMERGENCY / CONSENT FORM

FOR OFFICE USE ONLY:

School: _____ SASID # _____

Date Completed _____ Teacher _____

Grade _____ Homeroom # _____ Guidance _____

IF CHANGE OF ADDRESS OR PHONE, PLEASE CHECK

Student Name _____ Sex: M F
Last First Full Middle Name

Date of Birth _____ Birthplace _____
M D Year City State Country

Student Address _____ Home Phone _____

Father's Name _____ Home Phone _____

Address _____ Cell Phone _____
_____ email: _____

Name of Employer _____ Work Phone _____

Employer Address _____

Mother's Name _____ Home Phone _____

Address _____ Cell Phone _____
_____ email: _____

Name of Employer _____ Work Phone _____

Employer Address _____

Do Parents/Guardians Speak English? Yes No If not, what language spoken? _____

Does student speak a second language? (Specify) _____

Transportation: Walk _____ Car _____ Bus _____ (please check one)

Other students living at same address: List Name, Relationship & School _____

Persons to contact in emergency, or release your child to, if parent / guardian cannot be reached

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Person(s) having legal custody of student _____

Is any person legally prevented from having contact with student? Yes _____ No _____

IF YES, MUST ATTACH A COURT DOCUMENT

(Over)

Please list any known medical conditions: _____

Please list any known allergies: _____

Please list any medications student is taking: _____

Physician: _____

Address: _____ Phone: _____

Dentist: _____

Address: _____ Phone: _____

Hospital preferred in an emergency: _____

Medical directives you wish to make known: _____

As a precautionary measure, we would like to ensure that all students have access to medical treatment, if needed. In case of injury or illness requiring medical intervention, every effort will be made to notify parent / guardian. In the event that this is not possible, treatment will be initiated promptly by the school nurse, E.M.T. and / or local hospital facility.

I hereby authorize the _____ School through its medical staff and / or local ambulance service and hospital facility to act in the best interest of my son / daughter in the event of injury or medical problem requiring immediate attention. Exceptions, if any: _____

Please indicate your approval with your signature _____
Parent / Legal Guardian *Date*

I DO NOT AUTHORIZE THIS ACTION

Signature _____
Parent / Legal Guardian *Date*

I give my permission for the school nurse to share with the student's physician any information pertaining to the Student's Health Record.

Signature _____
Parent / Legal Guardian *Date*

I DO NOT AUTHORIZE THIS ACTION

Signature _____
Parent / Legal Guardian *Date*

I give my permission to the school nurse to share pertinent health information regarding the student with appropriate school personnel.

Signature _____
Parent / Legal Guardian *Date*

I DO NOT AUTHORIZE THIS ACTION

Signature _____
Parent / Legal Guardian *Date*