

**GERMAN-AMERICAN INTERNATIONAL SCHOOL
EMERGENCY INSTRUCTIONS**

STUDENT'S NAME	GRADE	BIRTHDATE	SEX	CITIZENSHIP(S) please include all
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ADDRESS (ANY CHANGES MUST BE VERIFIED WITH CENTRAL ATTENDANCE)

HOME PHONE: _____

CELL PHONE Mother: _____

CELL PHONE Father: _____

PARENT / GUARDIAN NAME	LEGAL CUSTODY YES <input type="checkbox"/> NO <input type="checkbox"/>	RELATIONSHIP	Last DTP: _____
ADDRESS IF DIFFERENT FROM ABOVE			
OCCUPATION	EMPLOYED BY		
BUSINESS ADDRESS AND PHONE NO.			
OTHER PARENT / GUARDIAN NAME	LEGAL CUSTODY YES <input type="checkbox"/> NO <input type="checkbox"/>	RELATIONSHIP	
ADDRESS IF DIFFERENT FROM ABOVE			
OCCUPATION	EMPLOYED BY		
BUSINESS ADDRESS AND PHONE NO.			
E-MAIL (please enter e-mail address accessible to parents and/or guardians)			

FOSTER CHILD? YES NO **Special custody arrangements** _____

Indicate below the action you want the school to take if injury or illness is of a serious nature and you cannot be reached. **The School has no trained medical personnel on campus. We use: 911** for emergencies (paramedics).

1) Student should be placed in the care of personal physician or dentist: YES NO

Name of Physician / Practitioner: _____

Address: _____ Phone: _____

Name of Dentist / Orthodontist: _____

Address: _____ Phone: _____

Name of Insurance Company: _____

Policy Number: _____

In the event the physician / dentist listed are unavailable, do you authorize any licensed physician / dentist to treat your child?
YES NO

2) In the event you cannot be reached, and for the protection of your child's health and welfare, do you authorize the school to obtain the necessary medical aid, including ambulance service, if needed, on your expense? YES NO

If no, specify instructions: _____

3) Religious exemptions: YES NO . If yes, provide school with official exemption notice.

In case of any emergency and the school is unable to reach you, please list persons, the school may contact whom you authorize to care for your child. The first name listed should be able to pick up your child at school in case of a serious emergency. These persons must be **local** residents who are generally at home or work nearby. **Persons listed must have a phone.**

NAME	ADDRESS	HOME PHONE	CELL PHONE
1			
2			
3			
4			

Day care – before / after school care provider:

Name / Address / Phone: _____

DATE / SIGNATURE OF PARENT / GUARDIAN: _____

CHILDREN IN FAMILY

NAME	SCHOOL	GRADE	BIRTHDATE	RELATIONSHIP TO STUDENT	LIVING AT

HEALTH HISTORY

In order to serve your child more effectively and to meet the requirements of state law, we request that you provide the following information:

- 1) Date of last physical examination: _____ Date of last dental examination: _____
- 2) Does your child wear glasses? YES NO Contact lenses? YES NO Hearing aid? YES NO
- 3) Indicate if your child is on continuing medication for non-episodic condition. YES NO
 What medication? _____ For what condition? _____ At what times? _____
- 4) Is there any physical condition which may present a medical emergency? YES NO
 If yes, please describe: _____

HEALTH PROBLEMS

Listed below are a number of health problems which may be characteristic of school-age children and may INTERFERE IN SOME WAY WITH THEIR SCHOOL PERFORMANCE. If the school needs to make special accommodations to address the problem and / or when your child is under the care of a physician to monitor the problem, please indicate below. Check all that apply.

IF NO HEALTH PROBLEM, CHECK HERE (00)

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| <p>____(51) ALLERGY
 Allergy (Special below)</p> <p>____(52) Asthma</p> <p>____(53) Bee Sting Allergy</p> <p>____(54) Hay Fever</p> <p>____(55) Reaction to Medication</p> <p>____(56) CARDIO VASCULAR
 Heart Disease or Defect</p> <p>____(57) High Blood Pressure</p> <p>____(58) Rheumatic Fever</p> <p>____(59) DERMATOLOGY
 Skin Condition</p> <p>____(60) EAR, NOSE, THROAT
 Ear, Nose or Throat</p> <p>____(61) Hearing Problems</p> <p>____(62) Nosebleeds</p> <p>____(63) Tooth or Gum Trouble</p> <p>____(64) ENDOCRINE
 Diabetes</p> <p>____(65) Growth Problems</p> <p>____(66) Hypoglycemia</p> <p>____(67) Thyroid Problems</p> <p>____(68) GASTROINTESTINAL
 Frequent Diarrhea</p> <p>____(69) Jaundice</p> <p>____(70) GENITOURINARY
 Bladder Trouble</p> <p>____(71) Enuresis (Bed Wetting)</p> <p>____(72) Frequent Stomach Aches</p> <p>____(73) Kidney Trouble</p> | <p>____(74) GYNECOLOGIC
 Severe Menstrual Cramps</p> <p>____(75) HEMATOLOGIC
 Anemia</p> <p>____(76) Excessive Bleeding or Hemophilia</p> <p>____(77) Sickle Cell Anemia</p> <p>____(78) MUSCULOSKELETAL
 Orthopedic Problems</p> <p>____(79) Scoliosis</p> <p>____(80) NEUROLOGIC
 Cerebral Palsy</p> <p>____(81) Epilepsy or Seizures</p> <p>____(82) Hyperactivity</p> <p>____(83) Migraine Headaches</p> <p>____(84) Attention Deficit Disorder (ADD)</p> <p>____(85) OPHTHALMOLOGY
 Color Vision</p> <p>____(86) Dizziness or Fainting</p> <p>____(87) Vision Problem or Abnormality</p> <p>____(88) PSYCHIATRIC
 Psychiatric Problems</p> <p>____(89) RESPIRATORY
 Respiratory Problems</p> <p>____(90) MULTIPLE PROBLEMS
 Refer to Student File</p> <p>____(91) OTHER</p> |
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Comments: _____

