ROCKINGHAM COUNTY PUBLIC SCHOOLS
EMERGENCY CARE PERMISSION

Student: _____
(Last Name) (First Name) (Middle Name)

School: _____ Bus #: _____

Grade: _____ Teacher: _____ Date of Birth: _____/_____/_____

☐ Custody Order **(written documentation required)**

Home Phone: _____ Cell Phone: _____ Email Address: _____

Parent/Guardian: _____

Address: _____

Mother's Place of Work: _____ Mother's Work Phone: _____ Cell Phone: _____

Father's Place of Work: _____ Father's Work Phone: _____ Cell Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Phone: _____ Cell Phone: _____

Name: _____ Relationship: _____ Phone: _____ Cell Phone: _____

In an emergency, the school has permission to call our family doctor or dentist listed below:

_____ _____
(Family Doctor) (Phone)

_____ _____
(Family Dentist) (Phone)

If an emergency occurs and we cannot be contacted, the school has our permission to take our child to the doctor or hospital at our expense. The doctor and/or hospital medical staff have our permission to provide the treatment necessary for the well-being of our child.

The Rockingham County Public School division is committed to protecting the privacy, security and integrity of individually identifiable information received from you on behalf of your child. We may use your information to provide treatment to your child or to disclose information with other health care providers as indicated on this form. The school division is prepared to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other regulatory requirements by adopting and adjusting policies and processes as necessary.

1. His/her last Tetanus shot was given about: _____

2. Is your child allergic to any medicine, food, or other substance? Yes ☐ No ☐ List: _____

3. Does your child have the following condition as diagnosed by a physician?
   ☐ asthma ☐ diabetes ☐ seizures ☐ allergy to insect bites
   List medication needed: _____

4. Prescription medication your child takes on a regular basis: _____

5. Other medical conditions the school should know about: _____

_____ _____/_____/_____
(Signature of Parent/Guardian) (Date)

For School Use Only
_____ Emergency Alert

Please return all copies to the Principal

(***Check all that apply***)

☐ School/Private Insurance
☐ Medicaid
☐ FAMIS

9/09