ACADEMIC YEAR 20__-20__
HEALTH SERVICESEMERGENCY INFORMATION SHEET
Hasting Public Schools Hastings-on-Hudson. New York 10706

Farragut Health Office 478-6224 Farragut Fax 478-6340 Hillside Health Office 478-6280 Hillside Fax 478-6279

Grade as of Sept_____
Teacher _____K-4 only
Bus # _____K-4 only

Student's Name _____ _____
(Last name) (First name)
Home Address _____
Home Telephone _____ D.O.B._____

Mother's Name_____
Does mother live with child? Yes____ No ___IF "NO" PUT ADDRESS & TELE# BELOW
Work #-_____ Cell # _____
Email _____
******** _____**

Father's Name _____
Does father live with child? Yes ____No ___IF "NO"PUT ADDRESS & TELE BELOW
Work # _____Cell # _____
Email _____

Emergency Contacts: Please list persons who will assume temporary care of your child if you can not be reached.

#1-Name_____Relationship_____
home # _____ work # _____ cell # _____
#2-Name_____Relationship_____
Home # _____ work # _____ cell # _____
#3-Name_____Relationship_____
home # _____ work # _____ cell # _____

Physician Name_____
Address _____ Tele #_____
Significant Medical History (please include any allergies, medical conditions and or medications)

In case of an accident or serious illness, I request that the school nurse, administrator or his/her designee seek medical care for my child and make any necessary medical decisions until I can be reached. I understand and accept that the information provided to the health office regarding my child may be provided to other Hastings school personnel on an "as needed" basis in order to ensure the safety and well being of my child.

Parent/Guardian (print)_____