

Biddeford School Department Student Emergency Information Form 2011/2012
(This information will be shared with Biddeford School Department employees as needed for the care of your child)

BHS (9-12) BMS (6-8) BIS (4-5) BPS (1-3) JFK (Kindergarten)

Student Name: _____ Certified from Birth Certificate By: _____
(for Kindergarten Students)

Male Female DOB: _____ Grade: _____ Bus # _____ Birthplace: _____

Primary language spoken at home: _____ With whom does the child reside? _____

Mother/Guardian Name: _____ Employer: _____

Address: _____ Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail Address _____

Father/Guardian Name: _____ Employer: _____

Address: _____ Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____ E-Mail Address _____

Stepfather's Name: _____ Stepmother's Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

E-Mail Address: _____ E-Mail Address: _____

Employer: _____ Phone: _____ Employer: _____ Phone: _____

Please list the name(s) and age(s) of other children living in the home (primary residency):

Males: _____ Females: _____

In case of emergency, the person(s) to be called when parent(s) or guardian can't be reached:

#1 Name: _____ Phone: _____ #2 Name: _____ Phone: _____

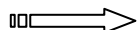
Babysitter Name: _____ Address: _____

Bussed to and from sitter? YES NO Phone: _____

NOTE: School Policy requires bus students to be picked up and dropped off at the same location (no exceptions)

FOR OFFICE USE ONLY

Grade/Room #: _____ / _____ Teacher: _____ Bus #: _____ Bus Stop: _____
Kindergarten Session: _____ AM / PM _____ Bus #: _____ Bus Stop: _____



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 (Continued)

Does the student have any of the following health concerns? (check all that apply)

- Contacts/glasses Kidney Hearing Problems Heart
 Vision Problems Asthma Seizures Intestinal
 Bleeding Disorder Diabetes ADD/ADHD Other _____

IMPORTANT: You need to contact the school nurse regarding any health concerns identified in the above list.

Will the school be required to administer medications to this student on a daily basis? YES NO
 If yes, you need to provide the following information:

Name of Medication	Dosage
1)	
2)	
3)	

Type of Allergy	Medication for Allergy
1)	
2)	
3)	

NOTE: If more room is needed, please attach a list of medications and/or allergies.

STUDENT INSURANCE INFORMATION

Insurance Company Name: _____ Policy #: _____

Maine Care #: _____ Expiration Date: _____

MEDICAL RELEASE PERMISSION

I, _____, give permission for my child, _____, to be treated at the Southern Maine Medical Center in case of emergency. It will be my responsibility to transfer him/her to another facility, if I choose. Our regular family physician is Dr. _____. The doctor's telephone number is _____.

PARENT/GUARDIAN Signature: _____ Date: _____

Witness Signature: _____ Date: _____