



Shadow Student EMERGENCY FORM

All information provided will be kept confidential.

Today's Date _____

Date of student shadow _____

STUDENT INFORMATION:

1. Last Name _____ First Name _____ Date of Birth _____ Grade _____
 Please list special health conditions (eg. Asthma, food allergies, ADD/ADHD, diabetes, epilepsy, etc.) and medications for this condition.
 Special Health Conditions _____ Medications _____
 **Will you allow the office to administer Tylenol / Advil / Tums to your child if necessary? YES / NO

2. Last Name _____ First Name _____ Date of Birth _____ Grade _____
 Please list special health conditions (eg. Asthma, food allergies, ADD/ADHD, diabetes, epilepsy, etc.) and medications for this condition.
 Special Health Conditions _____ Medications _____
 **Will you allow the office to administer Tylenol / Advil / Tums to your child if necessary? YES / NO

3. Last Name _____ First Name _____ Date of Birth _____ Grade _____
 Please list special health conditions (eg. Asthma, food allergies, ADD/ADHD, diabetes, epilepsy, etc.) and medications for this condition.
 Special Health Conditions _____ Medications _____
 **Will you allow the office to administer Tylenol / Advil / Tums to your child if necessary? YES / NO

HOME INFORMATION: Home Phone _____ Cell # _____
 Email _____ Work # _____
 Home Address _____ City _____ Zip _____

Parent Arranging for Shadow Day: Mother Father Guardian Other _____
 Student(s) live(s) with: Both parents Mother Mother & Step Father Father Father & Step Mother
 Guardian(s) – relationship to student(s) _____

MOTHER/Guardian Name _____	FATHER/Guardian Name _____
Home Phone (if different than above) _____	Home Phone (if different than above) _____
Work Phone _____ ext. _____	Work Phone _____ ext. _____
Cell Phone _____	Cell Phone _____

EMERGENCY CONTACT INFORMATION:

Please list an individual authorized to pick up your child (ren) and to be responsible for him/her/them if parents/guardians cannot be reached. No child will be dismissed to anyone other than those designated below:

Name _____	Relationship to student(s) _____	Home phone _____
		Work phone _____
		Cell phone _____

Medical Contacts and Insurance

Physician _____ Physician's Phone Number _____
 Dentist _____ Dentist's Phone Number _____
 Health Insurance Company _____ Policy # _____ Group # _____

Medical Release

In the event of an emergency and neither parent can be reached, I hereby authorize school officials to take whatever action is deemed necessary, in their judgment, for the health of my child(ren). I consent to any immediate medical procedures that the physician believes my child(ren) needs, with the understanding that efforts will continue to be made to contact me. I accept responsibility for all costs related to such treatment. I hereby release Eastbrook Academy, its employees, and chaperones from any and all liability in the event of injury.

Signature of Parent/Guardian _____ Date _____