

**Okeechobee County School Board  
Emergency Information**

Home Phone: _____	Grade: _____ Homeroom: _____	AM Bus: _____ PM Bus: _____
Student's Name: _____		Date of Birth: _____
Street Address: _____		City _____ Zip Code _____
Mailing Address: _____		City _____ Zip Code _____

Father/Male Guardian's Name	Contact Order ____	Work Phone	Business Name	Cell/Page/Other Phone
Mother/Female Guardian's Name	Contact Order ____	Work Phone	Business Name	Cell/Page/Other Phone
Emergency Contact Name	Contact Order ____	Home Phone	Work Phone	Cell/Page/Other Phone
Emergency Contact Name	Contact Order ____	Home Phone	Work Phone	Cell/Page/Other Phone
Emergency Contact Name	Contact Order ____	Home Phone	Work Phone	Cell/Page/Other Phone

Condition	Medication for Condition	Condition	Medication for Condition
<input type="checkbox"/> ADHD <input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Leukemia	_____
<input type="checkbox"/> Ulcer <input type="checkbox"/> Asthma requiring medication	_____	<input type="checkbox"/> Headaches <input type="checkbox"/> Nosebleeds	_____
<input type="checkbox"/> Diabetes <input type="checkbox"/> Ear Infections	_____	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Sickle Cell	_____
<input type="checkbox"/> Seizures <input type="checkbox"/> Heart Condition	_____	<input type="checkbox"/> Birth Defect <input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Kidney/Urinary Tract <input type="checkbox"/> Hemophilia	_____	<input type="checkbox"/> Hearing Impair. <input type="checkbox"/> Lung Disorder/TB	_____
<input type="checkbox"/> Hernia <input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Visual Impair <input type="checkbox"/> Stomach Problems	_____

Other, Please Specify \_\_\_\_\_

Allergies to Medications:  Yes  No Specify Medication Name(s) \_\_\_\_\_  
 Severe Allergic Reaction to bee stings, ant bites, food:  Yes  No Specify \_\_\_\_\_  
 Can you provide medical documentation of the above?  Yes  No  
 Pollen and Other Allergies  Yes  No Specify allergy and medications \_\_\_\_\_

Student covered by: Health Insurance \_\_\_\_\_ Yes \_\_\_\_\_ No Medicaid \_\_\_\_\_ Yes \_\_\_\_\_ No

Source of Medical Care: \_\_\_\_\_ No Regular Source \_\_\_\_\_ Florida Community Health Center  
 \_\_\_\_\_ Emergency Room \_\_\_\_\_ County Public Health Unit  
 \_\_\_\_\_ Private Physician/Clinic: Name \_\_\_\_\_

If your child has ever been seriously ill, had a serious accident, been hospitalized in the last 3 years, or has frequent minor illnesses, please explain: \_\_\_\_\_

Should your child's activities at school be restricted in any way due to a medical problem?  Yes  No  
If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Has your family experienced any of the following in the last year?

- |                                     |  |   |
|-------------------------------------|--|---|
| <input type="checkbox"/> Marriage   | <input type="checkbox"/> A Birth               | <input type="checkbox"/> Loss of Employment |
| <input type="checkbox"/> Death      | <input type="checkbox"/> Divorce               | <input type="checkbox"/> Serious Illness    |
| <input type="checkbox"/> Relocation | <input type="checkbox"/> Separation of Parents |   |

<u>Name(s) of Brothers and Sisters:</u>	<u>Grade</u>	<u>School</u>

Parental Consent: In the case of a medical emergency, the school has my permission to send my child to the nearest hospital or physician if unable to contact parent(s) or person(s) listed above. I hereby certify that the above information is true and correct.

\_\_\_\_\_  
Name of Parent/Guardian (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian