

INNOVATION ACADEMY CHARTER SCHOOL

2010-11 EMERGENCY INFORMATION

This form must be returned before your child starts the new school year. *PLEASE PRINT ALL INFORMATION.*
 This information is required of the parents/guardians of all enrolled students at the beginning of each school year. It is necessary so that your child can receive prompt attention in the event of serious injury or illness and will be kept confidential.

STUDENT INFO. Grade in September 2010: 5 6 7 8 9 10 11 12

Name: _____
(FIRST) (MIDDLE) (LAST)

Address: _____
(street address) (apt. no.)

_____, MA _____ Telephone: _____
(city/town) (zip code) (include area code)

Primary Language Spoken at Home: English Other (identify): _____

I _____ (name) _____ (relationship to child) should be the **first person contacted** in case of an emergency. Please use the following ways to contact me in this order:

1. _____, this is my:
2. _____, this is my:
3. _____, this is my:

*Your company's main number (in case we cannot reach you at your direct line): _____
 Place of Employment: _____ Occupation/Title: _____
 Location (town): _____ Work Days/Hours: _____

I _____ (name) _____ (relationship to child) should be the **2nd person contacted** if person #1 can not be reached in case of an emergency. Please use the following ways to contact me in this order:

1. _____, this is my:
2. _____, this is my:
3. _____, this is my:

*Your company's main number (in case we cannot reach you at your direct line): _____
 Place of Employment: _____ Occupation/Title: _____
 Location (town): _____ Work Days/Hours: _____

MOTHER/LEGAL GUARDIAN Name: _____ home phone number _____

LEGAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

CELL PHONE NUMBER: _____ WORK PHONE NUMBER: _____

FATHER/LEGAL GUARDIAN Name: _____ home phone number _____

LEGAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP _____

CELL PHONE NUMBER: _____ WORK PHONE NUMBER: _____

I GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO RELEASE MY CHILD FROM THE SCHOOL:

NAME _____ PHONE# _____ & NAME _____ PHONE# _____ /

IACS WILL OFTEN COMMUNICATE NON EMERGENCY INFORMATION THROUGH **EMAILS**. PLEASE PROVIDE AN ACTIVE EMAIL ADDRESS FOR ONE OR MORE PARENT/GUARDIANS. PLEASE PROVIDE RELATIONSHIP TO CHILD NEXT TO EMAIL ADDRESS.

_____ @ _____

Your child's doctor and the hospital you prefer he/she is taken to in case of severe injury:

Physician's Name: _____ Telephone: _____
 Preferred Hospital: _____ Location: _____
 Dentist: _____ Eye Doctor: _____
 Health Insurance Plan: _____ Policy No. _____

Is your child being treated for any of the following conditions? (please circle all that apply):

asthma eyeglasses contact lenses fainting seizures diabetes epilepsy scoliosis
 gastrointestinal / kidney / heart problems other: _____

Does your child uses an inhaler for asthma? Yes No If yes, the Prescription Medication Form must be completed.

Does your child have allergies? Yes No **If Yes, specify:** food bee/wasp seasonal

other: _____ Does it require an Epi-Pen? Yes No

Does your child take any medication(s)? Yes No **If Yes, specify:** _____

When taken? _____ Reason: _____

Additional comments, problems or anything else the school should know concerning your child's health. (e.g., currently under doctor's care, recent surgery, significant illness, chronic condition, physical limitation, etc.)

AUTHORIZATIONS:

I, _____, do hereby state that I am the natural parent/legal guardian
(parent/guardian full name-PRINT)
 having custody of _____, a minor son / daughter, born on
(student's full name - PRINT)
 ____/____/____, who resides with me at _____.
(mo) (day) (yr) (street address, city/town, state)

I agree that in an emergency, if I or person(s) designated above cannot be reached, my child will be taken to a hospital or emergency treatment facility by fire department ambulance or Designate. I authorize the Director, or the Acting Director, of the IACS to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to this minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the Commonwealth of Massachusetts, when the need for such treatment is immediate, and when efforts to contact me are unsuccessful.

Parent/Guardian Signature Dated: ____/____/____
(mo) (day) (yr)

I give permission for the school nurse, or designated school personnel, to administer over-the-counter medications (OTCs) to my child as needed (e.g. Tylenol, Advil, cough drops).

Parent/Guardian Signature Dated: ____/____/____
(mo) (day) (yr)

Field Trips (check those that apply):

- I give permission for a teacher, trained by the school nurse, to give my child his/her medication during field trips .
- I prefer to omit my child's medication for the day of any field trip.
- I give permission for this form to be used on any school-related field trip.

I give permission to the school nurse to share with appropriate school personnel medical information as he/she determines necessary for my child's health and safety.

Parent/Guardian Signature Dated: ____/____/____
(mo) (day) (yr)