Year of Graduation _________

Erskine Academy Emergency Card

Please Print

▫ Data Confirmed
(office use only)

Student Name ____

Name of Legal Parent/Guardian(s) with whom you live: ____

Mailing Address _______________________________________ Physical Address: ___________________________________

Mailing Town ____________________________________ State _____________ Zip ____________

Parent/Guardian _name_________________________________ Relationship to Student _____________________________

Phone # Home __________________ Cell_____________________ Work____________________

Email Address ____(please print clearly)*

Parent/Guardian _name_________________________________ Relationship to Student _____________________________

Phone # Home __________________ Cell_____________________ Work____________________

Email Address ____(please print clearly)*

** Email addresses are highly encouraged. Grade reports & messages will be sent to emails instead of mailing. If no email is assigned to a parent/guardian, report cards will be mailed. Emails will be used for classroom communication including parents, students and teachers.*

➔ ➔ *** * * Please turn over to complete the top portion of this form * * *** ➔ ➔

Office use only (cut here) ✂ - - - - - - - - - - - - - -

Erskine Academy Expanded Health Services

Student Name (please print): ____ **Grade**: __________ **DOB**: __________

Please circle:

Yes No I give permission for my child to use the Expanded Health Services offered through Erskine's Health Office.

Yes No I give the Nurse Practitioner and school nurse permission to share information about my child with his/her health care provider as necessary. (Refer to the Student Handbook for explanation of Expanded Health Services).

I give permission for the school nurse or other trained personnel to administer:

Yes No Acetaminophen (Tylenol) 1-2 tablets (325mg) every four hours as needed for minor discomfort

Yes No Ibuprofen 1-2 tablets (200mg) every four hours as needed for minor discomfort

Permission is valid for ***one*** *school year and consent by telephone will not be accepted.*

~ Do you have any illness, allergy, or condition that the school should be aware of? If so, please list:

____

____

~ List any medication you take: ____

____

Health Care Provider: ____ Phone: _______________________

Parent / Guardian Signature ____ **Date** _______________________

In Case of Divorce ~ Name of Other Parent: ____

Mailing Address ______________________________________ Physical Address: __________________________________

Mailing Town ___________________________________ State _____________ Zip ____________

Parent/Guardian _*name*_________________________________ Relationship to Student ____________________________

Phone # Home ___________________ Cell_____________________ Work____________________

Email Address ____(please print clearly)*

Parent/Guardian _*name*_________________________________ Relationship to Student ____________________________

Phone # Home ___________________ Cell_____________________ Work____________________

Email Address ____(please print clearly)*

In the event of an emergency, and you can not be reached, please list an alternative contact:

____________________________________	_________________________	________________________________
Name	Relationship	Number(s)

Town responsible for paying tuition (*circle one*) Chelsea China Jefferson Palermo
Somerville Vassalboro Whitefield Windsor Other ______________________

Parent / Guardian Signature ____ Date ____________________