HOWELL MOUNTAIN ELEMENTARY SCHOOL DISTRICT
Student Emergency and Release Form
CONFIDENTIAL

PLEASE PRINT IN INK

Student's Name:	Male/Female	Date of Birth:	
Home Address:	City:		Zip:
Mailing Address:	City:		Zip:
Family Physician:	Physician Phone:		
Insurance Company:	Insurance Policy Number:		

EMERGENCY CONTACTS

Parent/Guardian:	Relation:
Phone:	Alternate Phone:

Parent/Guardian:	Relation:
Phone:	Alternate Phone:

OTHER EMERGENCY CONTACTS ***(Only people in this section will be allowed to pick up your child. Use another sheet if needed)***

Name:	Relation:
Phone:	Alternate Phone:

Name:	Relation:
Phone:	Alternate Phone:

Name:	Relation:
Phone:	Alternate Phone:

Name:	Relation:
Phone:	Alternate Phone:

Name:	Relation:
Phone:	Alternate Phone:

Name:	Relation:
Phone:	Alternate Phone:

Parent/Guardian Signature Date:

SIGN BOTH SIDES
(OVER)

SPECIAL NEEDS:	Yes	No	Frequency and/or Severity	SPECIAL NEEDS:	Yes	No	Frequency and/or Severity
Allergies				Hearing Impaired			
Asthma				Nose Bleeds			
Bedwetting				Physical Handicap			
Behavioral or Cognitive				Sleepwalking			
Diabetes				Stomach Aches			
Epilepsy				Vegetarian/Vegan			
English Language Learner				Visually Impaired			
Fainting				Other			
Headaches				Other			

Please Explain any Item checked above:

MEDICATIONS:

Medications, including over-the-counter medications, can only be administered by designated trained personnel from your child's school, provided that *this form is signed by the authorized health care provider AND the parent or guardian.* Over-the-counter medications include, but aren't limited to: sunscreen, allergy remedies (Benadryl, etc), antiseptic and/or topical ointments, cold remedies, insect bite remedies, non-aspirin substitutes and poison oak remedies. Medications must be packaged individually in pharmacy-prepared containers (with only amount to be administered) and given directly to your school personnel. Medication labels must include:

Student's Name	Dose of Medication
Authorized Health Care Provider	Method of Administration
Name of Medication	Time of Administration

PHYSICIAN'S STATEMENT OF REQUIRED MEDICATON:

_____ should be given the following medication as designated below:
Student's Name

Medication	Dosage	Method of Administration	Time of Administration	Special Instructions and/or precautions

☐ Please allow _____ to keep an inhaler with him/her at all times. He/she is competent to safely self-administer medication.

☐ Please allow _____ to keep an epi-pen with him/her at all times. He/she is competent to safely self-administer medication.

Physician Name: Phone:

Signature: Date:

Parent/Guardian Signature Date: