

**HEALTH SERVICES**  
**VALLEY VIEW PUBLIC SCHOOL COMMUNITY UNIT DISTRICT 365-U**  
**PUPIL EMERGENCY INFORMATION SUPPLEMENT**

Bus No. \_\_\_\_\_

Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ M/F \_\_\_\_\_ Home Phone Number \_\_\_\_\_

Student's Street Address \_\_\_\_\_ City and Zip \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Child lives with: \_\_\_\_\_

**HEALTH HISTORY - Please give approximate dates & provide details as needed.**

Asthma	
Heart defect/Disease	
Seizures	
Psychiatric Treatment	
Frequent Ear Infections	
Severe Nosebleeds	
Severe Bee Sting Allergy	
Medication or Food Allergy	
Diabetes	
Does your child wear glasses?	
Other:	
List any medications your child takes: * If your child need to take any medicine at school, please obtain form from school office.	

**Adult Female Information** (Please Print) \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to student \_\_\_\_\_

Daytime Employer-Company Name/Department \_\_\_\_\_ Daytime Work Phone \_\_\_\_\_

Cellular Phone \_\_\_\_\_ Pager Number \_\_\_\_\_

**Adult Male Information** (Please Print) \_\_\_\_\_  
 First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Relationship to student \_\_\_\_\_

Daytime Employer-Company Name/Department \_\_\_\_\_ Daytime Work Phone \_\_\_\_\_

Cellular Phone \_\_\_\_\_ Pager Number \_\_\_\_\_

**Emergency Contact Information Other than Parents** (Please Print)

_____	_____	_____
First and Last Name	Daytime Telephone Number	Relationship to Student
_____	_____	_____
First and Last Name	Daytime Telephone Number	Relationship to Student
_____	_____	_____
First and Last Name	Daytime Telephone Number	Relationship to Student
_____	_____	_____
First and Last Name	Daytime Telephone Number	Relationship to Student
_____	_____	_____
First and Last Name	Daytime Telephone Number	Relationship to Student

**Parent permission to provide a physician and hospital treatment:**

**NOTE:** *It must be clearly understood that the hospital will not provide any medical attention, except in very serious emergency cases, until a parent comes personally to sign a release.*

I give my permission for the school to call a physician or have my child taken to a hospital in the event of a serious accident or illness if I cannot be contacted. I will assume responsibility for this.

Signature \_\_\_\_\_ Date \_\_\_\_\_