

**GREATER LOWELL TECHNICAL HIGH SCHOOL**

**EMERGENCY INFORMATION**

**2020-2021**

TO BE COMPLETED BY LEGAL PARENTS/GUARDIANS:

Legal Parent/Guardian:     Both Parents     Father     Mother     Other \_\_\_\_\_

Student Lives with:         Both Parents     Father     Mother     Other \_\_\_\_\_

In case of emergency during school hours, it is necessary to contact parents/guardians in order to provide doctors and/or hospitals permission to treat minors in emergency situations. **It is of the utmost importance that you notify us immediately of any address or telephone number changes.**

Please Print

STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_  
                                Last                                First                                Middle

ADDRESS: \_\_\_\_\_  
                        Number        Street  City/Town                                Zip Code

HOME TELEPHONE # \_\_\_\_\_ CELL PHONE# \_\_\_\_\_

STUDENT'S BIRTH DATE: Month: \_\_\_\_ Day: \_\_\_\_ Year: \_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

FATHER/GUARDIAN FULL NAME: \_\_\_\_\_

PLACE OF WORK: \_\_\_\_\_

WORK TELEPHONE NUMBER: Area Code \_\_\_\_ Number \_\_\_\_\_ Ext. \_\_\_\_\_

FATHER'S PRIMARY LANGUAGE: \_\_\_\_\_

Would you prefer communication in a language other than English?

No         Yes, If yes, please indicate language \_\_\_\_\_

MOTHER/GUARDIAN FULL NAME: \_\_\_\_\_

PLACE OF WORK: \_\_\_\_\_

WORK TELEPHONE NUMBER: Area Code \_\_\_\_ Number \_\_\_\_\_ Ext. \_\_\_\_\_

MOTHER'S PRIMARY LANGUAGE: \_\_\_\_\_

Would you prefer communication in a language other than English?

No         Yes, If yes, please indicate language \_\_\_\_\_

STUDENT'S HEALTH INSURANCE COMPANY: \_\_\_\_\_

STUDENT'S HEALTH INSURANCE CERTIFICATE NUMBER: \_\_\_\_\_

NAME OF STUDENT'S PHYSICIAN: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

DO YOU GRANT PERMISSION TO NOTIFY TEACHERS OF ANY MEDICAL CONDITION? Yes  No

DOES STUDENT REQUIRE AN EPI-PEN? Yes  No  IF YES, PARENT MUST PROVIDE THE EPI-PEN TO THE SCHOOL.

**OVER**



DOES STUDENT HAVE ANY PHYSICAL OR PSYCHOLOGICAL ISSUES AND OR ALLERGIES?

No  Yes If yes, please explain \_\_\_\_\_

DOES STUDENT HAVE A DISABILITY? Yes  No

If yes, Please explain: \_\_\_\_\_

IEP (Individual Education Plan)  504 Plan

• IS THE STUDENT ON ANY MEDICATION? Yes  No

If yes, please state type of medication \_\_\_\_\_

If yes, will it be taken during school hours? Yes  No

• I GIVE THE SCHOOL NURSE PERMISSION TO ADMINISTER TO MY CHILD:

TYLENOL Yes  No  COUGH DROPS Yes  No   
(325mg, 2 tabs)

MIDOL Yes  No  ANTACID Yes  No   
(for menstrual cramps) (Tums, for upset stomach)

If neither parent can be located in the event of an emergency, please supply us with two names, other than parents, who are authorized by you to give assistance.

**THE PEOPLE YOU CHOOSE MUST BE AVAILABLE DURING SCHOOL HOURS.**

NAME OF PERSON \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ADDRESS OF PERSON: \_\_\_\_\_  
Number Street City/Town

NAME OF PERSON: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ADDRESS OF PERSON \_\_\_\_\_  
Number Street City/Town

**IT IS THE RESPONSIBILITY OF THE PARENTS/GUARDIANS TO PROVIDE TRANSPORTATION FOR THEIR SICK OR INJURED CHILD. ANY ILLNESS OR INJURY OCCURRING AT HOME IS NOT THE RESPONSIBILITY OF THE SCHOOL NURSES AND SHOULD BE TAKEN CARE OF BY THE PARENTS/GUARDIANS.**

School nurses are at the school for illnesses occurring during the school hours and school injuries only. They are responsible for initial first aid treatment and not for follow-up treatment.

IF THE STUDENT NEEDS TO BE TRANSPORTED VIA AMBULANCE, THEY WILL BE TRANSPORTED TO THE NEAREST HOSPITAL, LOWELL GENERAL HOSPITAL.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

***This form should be completed and returned to Greater Lowell Tech within TEN days of receipt.***