



Dassel-Cokato Schools - ISD # 466
2011-2012 Health & Emergency Contact Form
 4852 Reardon Ave SW, Suite 1600
 Cokato, MN 55321
 Phone: 320-286-4100 Fax: 320-286-4201
 Tracy Kraemer, Licensed School Nurse



PLEASE NOTE, ONLY ONE FORM IS NEEDED PER FAMILY

Parent/Guardian Last Name:	Parent/Guardian First Name:	If you have a change of address, phone number, email address, etc, please contact the office.

Household Student(s) Information

Please describe any health concerns and/or medication information for each student.
 For example: Allergies, Asthma, Diabetes, Mental Health, Seizures, Sensory Impairments, etc.

Student Name (list all student(s) in household)	D.O.B.	School (CE, DE, MS, HS)	Health & Medication Information: Specific Concern or None	
			<input type="checkbox"/> None	
			<input type="checkbox"/> None	
			<input type="checkbox"/> None	
			<input type="checkbox"/> None	
			<input type="checkbox"/> None	
			<input type="checkbox"/> None	

Emergency Contact(s) Information is the same as last school year.
 If you check this box, no further information is needed. Please sign below.

Emergency Contact(s) Information has changed.
 If you check this box, please update information below as needed and sign below.

Emergency Contact Information

In emergency situations, parent/guardian will be contacted first. The emergency contacts provided below are the only contacts that may transport or care for your child if you cannot be reached. In case of serious accident or illness at school, 911 will be called. The parent/guardian is responsible for all expenses.

Emergency Contact 1 (Other than Parent/Guardian)

Last Name:	First Name:	Home Phone Number:
Cell Phone Number:	Work Phone Number:	
Relation to Student(s): <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Family Friend <input type="checkbox"/> Grandparent <input type="checkbox"/> Neighbor <input type="checkbox"/> Step-parent <input type="checkbox"/> Sibling <input type="checkbox"/> Other (Please Specify): _____		

Emergency Contact 2 (Other than Parent/Guardian)

Last Name:	First Name:	Home Phone Number:
Cell Phone Number:	Work Phone Number:	
Relation to Student(s): <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Family Friend <input type="checkbox"/> Grandparent <input type="checkbox"/> Neighbor <input type="checkbox"/> Step-parent <input type="checkbox"/> Sibling <input type="checkbox"/> Other (Please Specify): _____		

Clinic/Hospital/Dentist Preference:

Clinic Preference:	Clinic Phone:
Hospital Preference:	Hospital Phone:
Dentist Preference:	Dentist Phone:

Parental Consent

If considered necessary by school nurse, this health information may be shared with other school personnel: Yes No
 I certify that all information on this form is correct to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____

This information is confidential and is for health office use only.

Office Use Only: (Updated)