

**BENTON SCHOOL DISTRICT**  
**EMERGENCY INFORMATION 2018-19**

Dear Parent(s):

All students are required to have an emergency form on file. Please complete and return this form promptly. Also, please notify us of any changes in the information as it occurs. THIS FORM IS TO BE COMPLETED BY A PARENT.

**CHILD'S LEGAL NAME** \_\_\_\_\_ **BIRTHDATE** \_\_\_\_\_ **GRADE** \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE # \_\_\_\_\_ PLACE OF EMPLOYMENT \_\_\_\_\_

CELL PHONE # \_\_\_\_\_ E-mail Address \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

ADDRESS \_\_\_\_\_

WORK PHONE # \_\_\_\_\_ PLACE OF EMPLOYMENT \_\_\_\_\_

CELL PHONE # \_\_\_\_\_ E-mail Address \_\_\_\_\_

PARENT'S MARITAL STATUS (Circle One) SINGLE MARRIED DIVORCED SEPARATED WIDOW  
IF DIVORCED/SEPARATED, WITH WHOM DOES THE CHILD RESIDE? \_\_\_\_\_

If you cannot be reached, please contact: (**Please list at least two people**):

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Phone# \_\_\_\_\_ Address \_\_\_\_\_

If no one can be reached immediately, does the school have permission to take your child to the nearest medical facility? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please indicate the plan the school should follow: \_\_\_\_\_

{Please note, that in true life-threatening emergency, EMS or EMT personnel take individuals to the closest facility to provide the most rapid intervention possible}

Family Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

If physician is unavailable, may school call an alternate physician? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your child have any unusual health conditions? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please check and **DESCRIBE**: Diabetes \_\_\_\_\_ Heart \_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Seizures \_\_\_\_\_

Other \_\_\_\_\_

(1<sup>st</sup>-6<sup>th</sup> only) - Does your child have permission to participate in the fluoride mouth rinse program? This is a weekly one minute mouth rinse that compliments good oral hygiene practices at home for the prevention of tooth decay. Yes, they will participate this year \_\_\_\_\_ No, they will not participate this year \_\_\_\_\_

Does your child take medication regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please name medication and dosage \_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_