75.090 REV. 1/06 NHS

STUDENT ATHLETIC EMERGENCY INFORMATION

EVANSVILLE-VANDERBURGH SCHOOL CORPORATION

PLEASE USE BLACK INK & NOTIFY A.D. WITH ANY UPDATES

SCHOOL YEAR _____ to _____

NAME _____ GRADE _____
LAST FIRST MIDDLE

DATE OF BIRTH _____ HOME PHONE _____

STUDENT'S HOME ADDRESS _____ ZIP _____ LIVING WITH _____

FATHER/GUARDIAN _____ ADDRESS _____ PHONE _____

MOTHER/GUARDIAN _____ ADDRESS _____ PHONE _____

FATHER/GUARDIAN E-MAIL _____ MOTHER/GUARDIAN E-MAIL _____

FATHER/GUARDIAN WORKPLACE _____ PH# _____ CELL _____

MOTHER/GUARDIAN WORKPLACE _____ PH# _____ CELL _____

- IS THERE ANYONE WHO BY COURT ORDER OR DECREE IS DESIGNATED AS THE PRIMARY OR SOLE CUSTODIAL PARENT? _____
- IS THERE ANYONE WHO IS RESTRAINED FROM PICKING UP THIS CHILD? _____

I UNDERSTAND IT IS MY RESPONSIBILITY TO KEEP THE SCHOOL INFORMED ABOUT SUCH MATTERS AND TO PROVIDE COPIES OF RELEVANT COURT ORDERS AND DECREES TO SCHOOL OFFICIALS.

IN CASE OF EMERGENCY WHEN PARENTS CANNOT BE LOCATED, WHOM SHOULD WE CONTACT LOCALLY?

NAME _____ HOME PH# _____ CELL# _____ WORK# _____
(1ST CHOICE) RELATIONSHIP

NAME _____ HOME PH# _____ CELL# _____ WORK# _____
(2ND CHOICE) RELATIONSHIP

MY CHILD IS ALLERGIC TO THE FOLLOWING: _____

INDICATE ANY PERTINENT HEALTH PROBLEMS OR CONDITIONS: (LIST ROUTINE MEDICATIONS, GLASSES, CONTACT LENS, ETC.)

_____

_____

IF A DOCTOR'S/DENTIST'S CARE SEEMS NECESSARY, MAY WE CALL YOUR DOCTOR/DENTIST? YES _____ NO _____

NAME OF FAMILY DOCTOR _____ PHONE _____

NAME OF FAMILY DENTIST _____ PHONE _____

HOSPITAL PREFERENCE _____

INSURANCE COVERAGE _____ YES _____ NO

1. IN CASE OF AN EMERGENCY INVOLVING YOUR CHILD, IT IS THE POLICY OF E-VSC TO RENDER FIRST AID TREATMENT WHILE CONTACTING PARENTS/GUARDIANS FOR FURTHER INSTRUCTIONS. IN THE EVENT THAT THE PARENTS/GUARDIANS CANNOT BE CONTACTED, SCHOOL OFFICIALS WILL CONTACT 911.
2. INFORMATION ON THIS FORM MAY BE SHARED WITH THE APPROPRIATE E-VSC PERSONNEL FOR HEALTH AND EMERGENCY PURPOSES.

NOTE: IF AT THE END OF THE SCHOOL DAY, YOUR CHILD IS ILL OR HAS NOT BEEN PICKED UP AND YOU OR YOUR EMERGENCY CONTACT DESIGNEE(S) CANNOT BE REACHED, CHILD PROTECTIVE SERVICES WILL BE CONTACTED.

- "I UNDERSTAND THAT AS PARENT/LEGAL GUARDIAN I MAY GIVE AUTHORIZATION FOR THE DISCLOSURE OF MY CHILD'S PROTECTED HEALTH INFORMATION. I UNDERSTAND THAT SUCH HEALTH INFORMATION IS PROTECTED BY FEDERAL REGULATIONS UNDER EITHER THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OR THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974 (BUCKLEY AMENDMENT) AND MAY NOT BE DISCLOSED WITHOUT EITHER PARENT/LEGAL GUARDIAN AUTHORIZATION UNDER HIPAA OR CONSENT UNDER THE BUCKLEY AMENDMENT. I HEREBY GIVE PERMISSION TO E-VSC TO SHARE INFORMATION RELEVANT TO MY CHILD'S HEALTH CONDITION WITH APPROPRIATE SCHOOL PERSONNEL OR HEALTH CARE PROVIDERS WHEN NEEDED TO MEET MY CHILD'S HEALTH AND SAFETY NEEDS. I ALSO GIVE PERMISSION TO EXCHANGE INFORMATION WITH MY CHILD'S PRIMARY HEALTH CARE PROVIDERS FOR THE PURPOSE OF REFERRAL, DIAGNOSIS AND TREATMENT. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFICATION IN WRITING TO E-VSC, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON THE ACTIONS OF THOSE REPRESENTING E-VSC PRIOR TO RECEIVING THE REVOCATION."

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER THE DATED SIGNATURE.

PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____