School Year _____ / _____
Campus # _____

KLEIN INDEPENDENT SCHOOL DISTRICT
Clinic Emergency Procedure Information

Grade _____ Klein ID# _____
Teacher _____

LEGAL Name of Student _____
(Please PRINT) LAST Name FIRST Name MIDDLE (Use NMI if none)

Birth Date: _____ (Month/Date/Year) **Name Student 'Goes by'** _____ **Male** **Female** **HOME PHONE** _____/_____/_____

Home Street Address _____ **Apt.** _____ **City** _____ **Zip** _____

Primary Health Care Provider Name _____ **Office Number** _____/_____/_____

List CURRENT Medical Problems or Allergies _____

List ALL CURRENT medications _____

Student *lives with* Parent(s)/Guardian(s)

LEGAL Name of student's Parent(s)/Guardian(s) **circle one → (A) only (B) only BOTH**

Parent/Guardian (A) _____ **Daytime/ Work Number** _____/_____/_____ **Cell #** _____/_____/_____

Relationship: Mother/Father/Step-parent/Guardian/Other_____ **Email**_____

Parent/Guardian (B) _____ **Daytime/ Work Number** _____/_____/_____ **Cell #** _____/_____/_____

Relationship: Mother/Father/Step-parent/Guardian/Other_____ **Email**_____

If there are any medical reasons why my child cannot fully participate in school physical activities, I will send a written notice to the school principal and arrange a conference to discuss this matter during the first week of enrollment or within one week after discovery of such condition. If my child needs any prescription medication I will deliver both a doctor's written notification and medication in the original prescription container. I also agree to pick up any unused medication. I understand that students are not allowed to transport prescription medication. I authorize health related information to be released to appropriate staff for the care, safety, and welfare of my child.

"In case of accident or serious illness, I request the school authorities to contact me. If I cannot be reached I herewith authorize the school administration to call the physician indicated above. If it is impossible to contact the physician, I authorize the teacher/sponsor to arrange for all necessary medical services for said child or children on my behalf and I will be responsible for all medical costs incurred."

BOTH SIGNATURES ARE NOT REQUIRED. HOWEVER, IF ONLY ONE SIGNS, THAT PERSON WILL HAVE THE EXCLUSIVE AUTHORITY TO REMOVE THE STUDENT FOR AN EARLY DISMISSAL DURING THE SCHOOL DAY OR TO REQUEST CHANGES RELATED TO THE STUDENT'S EMERGENCY PROCEDURE DURING THE CURRENT SCHOOL YEAR.

SIGN HERE➔ _____ **Date** _____/_____/_____
Parent/Guardian Signature

SIGN HERE ➔ _____ **Date** _____/_____/_____
Parent/Guardian Signature

Rev. 05/02 Atty

KISD Form # 196050

Please check the type of medical insurance you have for this child:

CHIP ☐ **Medicaid** ☐ **Harris County Hospital District Gold Card** ☐ **Private Insurance** ☐ **None** ☐

Emergency Information: Parent(s)/Guardian(s) listed on front of card will be called first. *Persons below will then be called in the order listed.*

	(1)	*(2)*	*(3)*
Notify			
Work Phone			
Relationship			
Additional info.			

Date	Health Services Notes	Signature

Clear Form