PLYMOUTH-CANTON COMMUNITY SCHOOLS
P-CEP STUDENT EMERGENCY INFORMATION

PLEASE PRINT

LEGAL LAST NAME | FIRST | MIDDLE INIT | MALE / FEMALE GENDER (CIRCLE ONE)

HOUSE # | STREET NAME | APT # | CITY | ZIP CODE | BIRTHDATE

HOME PHONE | Y N Unlisted? | STUDENT I.D. # | HOME SCHOOL Canton, Plymouth, or Salem | 20 YEAR OF GRAD | COUNSELOR

STUDENT E-MAIL ADDRESS _____

STUDENT RESIDES WITH: *(PLEASE CIRCLE)* MOTHER FATHER BOTH PARENTS LEGAL GUARDIAN

IN CASE OF EMERGENCY, PLEASE PROVIDE A CURRENT DAYTIME PHONE OF PARENT/LEGAL GUARDIAN

Please indicate in the boxes below "☐" what ORDER to be called (ex: 1, 2, 3)

MOTHER/GUARDIAN	☐ ( )	☐ ( )
LAST NAME, FIRST	HOME PHONE	WORK PHONE ☐ ( )
ADDRESS (IF DIFFERENT FROM ABOVE)	E MAIL ADDRESS	CELL PHONE
FATHER/GUARDIAN	☐ ( )	☐ ( )
LAST NAME, FIRST	HOME PHONE	WORK PHONE ☐ ( )
ADDRESS (IF DIFFERENT FROM ABOVE)	E MAIL ADDRESS	CELL PHONE

ADDITIONAL PERSONS AUTHORIZED TO PICK UP STUDENT IF PARENT IS UNAVAILABLE

1) NAME _____ / Relationship PHONE ( ) _____

2) NAME _____ / Relationship PHONE ( ) _____

3) NAME _____ / Relationship PHONE ( ) _____

IF NON-ENGLISH SPEAKING HOME: ***(language in home)***	**ENGLISH SPEAKING EMERGENCY CONTACT NAME & PHONE NUMBER:**

Physician authorization required if medication is administered at school

HEALTH INFORMATION PROVIDED ON THIS FORM AND INFORMATION SUBMITTED ON PHYSICAL HEALTH APPRAISALS MAY BE SHARED WITH SCHOOL PERSONNEL, WHO ARE INVOLVED WITH THE HEALTH AND SAFETY OF MY CHILD. IF SCHOOL PERSONNEL ARE UNABLE TO REACH ME OR A PERSON WHOM I HAVE DESIGNATED, I HEREBY AUTHORIZE THEM TO SECURE EMERGENCY MEDICAL TREATMENT AS NECESSARY. I AGREE TO PAY ALL EXPENSES INCURRED BY THE EMERGENCY CARE.

REQUIRED

PARENT OR GUARDIAN SIGNATURE: **DATE:**

STUDENT HEALTH INFORMATION HEALTH CONCERNS

___ ALLERGIES
___ ARTHRITIS
___ ASTHMA
___ DIABETES
___ EMOTIONAL
___ HEARING
___ HEART CONDITION
___ KIDNEY DISEASE
___ SEIZURES
___ VISION
___ WALKING / MOBILITY
___ OTHER
___ NONE KNOWN

EXPLAIN: _____

DOES THIS STUDENT HAVE ANY PHYSICAL RESTRICTION(s)? YES _____ NO _____

EXPLAIN: _____

DOCTOR'S NOTE REQUIRED IF RESTRICTION INCLUDES PHYSICAL EDUCATION

MEDICATION -
LIST ALL MEDICATIONS AND DOSES THIS STUDENT USES REGULARLY

I agree to review the ***STUDENT HANDBOOK*** to understand the rights and responsibilities pertaining to students. I agree to abide by the rules, procedures and policies of the District. If I have questions, I will contact the administrator for more information.

Parent Initials: _____ Student signature: _____ Date: _____

Revised 12/1/14 st