Hopkins Public Schools

EMERGENCY REFERRAL AND HEALTH INFORMATION

Student Name

Preferred/Nickname	Grade	Advisor	Birthdate	Gender	Race/Ethnicity

Address:	
City, State, Zip:	
Home Phone Number:	

Please review the information, update emergency contacts, indicate any other health information, and sign the form.

HOUSEHOLD CONTACT(s)

Relation to Student	Name of Contact	Home Phone	Work Phone	Cell Phone

EMERGENCY CONTACT(s) (Please include your physician's name and number)

Relation to Student	Name of Contact	Home Phone	Work Phone	Cell Phone

IMMUNIZATION RECORD

Type of Vaccine	DTP	Polio	Hepatitis B	MMR	Chickenpox
1st Dose					
2nd Dose					
3rd Dose					
4th Dose					
5th Dose					
6th Dose					

HEALTH CONDITIONS

Known Condition:

ALLERGIES

Known Allergy:

MEDICATIONS

Known Medication:

If your child becomes ill or injured, the school will attempt to call the parent/guardian at home or at work. If you cannot be reached the school will attempt to call one of the emergency contacts listed above.

In case of serious accident/injury/illness I hearby authorize that the school can call the doctor listed above and/or 911 if necesary. Should my child need to be sent to a hospital, I would prefer:

To ensure the health and safety of your child, this information my be shared with school district staff or emergency personnel.

Parent/Guardian Signature

Date