Lincoln-Way Community H.S. D210
Student Emergency Information

Please complete this form in its entirety. The information on this form is necessary should we need to contact you and is considered confidential.

PLEASE PRINT ALL INFORMATION

STUDENT INFORMATION:

Student Name: ID#:

Date of Birth: Age: Gender:

Address:

Home Phone #:
Work Phone #:

Mobile Phone #:

PARENT/GUARDIAN INFORMATION:

Parent/Guardian Name (Primary): Relationship to student:

Address:

Home Phone #:
Work Phone #:

Mobile Phone #:

Parent/Guardian Name (Secondary): Relationship to student:

Address:

Home Phone #:
Work Phone #:

Mobile Phone #:

Emergency Contact (if different from Parent/Guardian):

Relationship to student:

Address:

Home Phone #:
Work Phone #:

Mobile Phone #:

Allergies:

Conditions requiring special consideration (medical/physical):

Does your student require: (A) **Epipen** Yes ☐ No ☐ (B) **Inhaler** Yes ☐ No ☐ (C) **ANY MEDICATION CURRENTLY TAKEN:** (Type of medication and time of administration):

Has the student lost a paired organ (kidney, etc.)?	YES	NO
Is the student epileptic?	YES	NO
Has the student had any seizures?	YES	NO
Is the student diabetic?	YES	NO
Is the student allergic to bee stings?	YES	NO
Does the student wear glasses or contact lenses?	YES	NO
Is the student allergic to any medications?	YES	NO

If yes, list ALL medical allergies:

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Student's Physician:	Phone #:
Student's Dentist:	Phone #:

MEDICAL CONSENT: I hereby give my consent/permission to any sponsor or coach of any activity in which my child is at or participating in for Lincoln-Way Community H.S. D210, and at the right, on my behalf and in my stand, to arrange for licensed and certified physicians and/or athletic trainers to render and provide immediate treatment to my child as to injuries that may be sustained during practice or in an active interscholastic competition, and all without necessity of any other further or additional express authorization by me other than this authorization.

My above permission and consent also extends to the right of any such supervising sponsor or coach or school personnel to arrange for immediate medical treatment and for them to apply such emergency techniques as may be necessary to my child where the same, in their judgment, is deemed appropriate by reason of any injury sustained by my child, and where the same, in their judgement, is deemed reasonably necessary to preserve life or limb of my child

Parent/Guardian Name:	Date:
(PLEASE PRINT)	
Parent/Guardian Signature:	

HEALTH INSURANCE INFORMATION:

Company Name:	Policy #:	Group #:
Parent/Guardian Name:		Date:
(PLEASE PRINT)		
Parent/Guardian Signature:		

NOTICE TO PARENT/GUARDIAN:
The District carries student accident and catastrophic student accident coverage for all students. The coverage is applicable for any accidental injuries a student incurs during the school day or at a district sponsored/supervised event. The coverage is secondary to any health insurance the student may have through their parent or guardian.

Note: The accident policy benefits are limited and may not provide 100% coverage. Accidental medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Parent/Guardian Name:	Date:
(PLEASE PRINT)	
Parent/Guardian Signature:	