❑ **Do Not Resuscitate Order (or) Advanced Directive on File** **SCHOOL ONLY**

Bus #: _____ Driver: _____

ANNUAL EMERGENCY INFORMATION/PERMISSION FORM
THIS FORM MUST BE COMPLETED AND RETURNED AS SOON AS POSSIBLE

_____ _____ _____ _____
Individual's Name | Street Address | City/State/Zip | Phone

_____ _____ _____ _____ _____
Date of Birth | Social Security Number | Medicaid Number | School District: *(Birth - 22 years)* | Medicare/Insurance #

_____ _____ _____
Additional Agency: *(if applicable)* | Agency Contact Person: *(if applicable)* | Agency Phone/Cell

_____ _____
Mother/Legal Guardian Name | Mother/Legal Guardian Address

_____ _____ _____ _____ _____ _____
Home Phone | List to Call | Cell Phone | List to Call | Work phone | List to call

_____
Mother's Employer's Name *(if applicable)*

_____ _____
Father/Legal Guardian Name | Father/Legal Guardian Address

_____ _____ _____ _____ _____ _____
Home Phone | List to Call | Cell Phone | List to Call | Work phone | List to call

_____
Father's Employer's Name *(if applicable)*

List Medical Contacts, In Case of Emergency:

Physician: _____ Dentist: _____
Street Address: _____ Street Address: _____
City/State/Zip: _____ City/State/Zip: _____
Phone: _____ Phone: _____

Authorization of Emergencies:

List 2 Emergency Contacts for use ONLY if parent cannot be contacted

Name/Relationship: _____ Name/Relationship: _____
Street Address: _____ Street Address: _____
City/State/Zip: _____ City/State/Zip: _____

Please select 1, 2 or 3 to set call order of phone number used to reach Emergency Contact

Home: _____ Call Order _____ Home: _____ Call Order _____
Cell: _____ Call Order _____ Cell: _____ Call Order _____
Work: _____ Call Order _____ Work: _____ Call Order _____

Child's Health Information:

Child's Chronic Medical/Health Needs:_____

_____

Known Allergies *(NOTE: If bee sting allergy: If stung by bee, stop bus, administer EPI-Pen, Call 911, comfort individual & pay attention to symptoms so you can give an accurate report).* _____

Hospital Preference: Lanes Ambulance will transport to one of the following: *CHOOSE ONE*:
❑ Trumbull ❑ St. Joe's ❑ St. Elizabeth – Downtown ❑ Akron Children's in Boardman

Type of Diet: ❑ Regular ❑ Other *(please name & explain)* _____
Restrictions:_____

Adaptive Devices Used By This Person: ❑ Dentures ❑ Eyeglasses ❑ Braces ❑ Splints ❑ Orthotics ❑ List Others:
_____

Ambulation: ❑ Independent ❑ Assist ❑ Walker ❑ Cane _____
❑ Wheelchair – *Type of Chair: ❑ Manual/ ❑ Electric *Type of Seat: ❑ Standard/ ❑ Gel _____

Communication: ❑ Verbal ❑ Non-Verbal ❑ Uses Sign Language ❑ Gestures _____

Signature: _____ Date: _____

Name: _____

PERMISSIONS

I have reviewed and understand the conditions of this Emergency Information/Permission Form.
My initials as marked and my signature below indicate I agree to cooperate with the following conditions:

Initial Each Box	Please read carefully and initial each separate type of permission listed below:
	Permission to Release Medical Information: I hereby give my permission that health/medical/nursing information may be shared with Fairhaven staff, including nursing, transportation, ambulance staff and emergency medical staff who may need to treat or work with this person.
	Treating and Transporting in Emergency Situations: In all cases, nurses and/or leadership will use their professional judgment and 911 will be contact first when it is determined immediate medical treatment is required. Fairhaven will provide first aid and will make efforts to contact the parent/guardian/caregiver as soon as feasible. Payment of fee will be the responsibility of the parent/caregiver/guardian.
	Photos: I understand that at times various media or promotional coverage of Fairhaven events will take place for publicity and/or public relations purposes. I further understand that permission is not necessary when individuals are not individually identified. Photos taken for identification purposes require permission. ❑ Yes, ***I give my permission*** for pictures and photos that individually identify students and enrolled adults. ❑ No, ***I do not give my permission***.
	Community Programming: Fairhaven will send notification of planned and supervised community programming. ❑ Yes, ***I give my permission*** for participation in community programming. ❑ No, ***I do not give my permission.***

Registration Authorization:

I authorize the following to be listed on the parent roster:
My Child's Name: ❑ Yes ❑ No Family Name: ❑ Yes ❑ No
Phone Numbers: ❑ Yes ❑ No ❑ Cell ❑ Home ❑ Work

Exempt from immunizations because of religious conviction: ❑ Yes ❑ No

Child immunization records attached: ❑ Yes ❑ No

Annual Class Roster: Each year the program prepares a roster for each group of children. This roster ***will not*** be furnished to any persons other than parents of children enrolled in our program.

Signature of Authorized Family Member/Guardian: _____ Date: _____

Takes Medications:

At Home: ❑ Yes ❑ No At School: ❑ Yes ❑ No

Does this person need treatments to be given at school? ❑ Yes ❑ No

When more information is needed, family or guardian will be contacted.

❑ **Known Seizure History:** ❑ Yes ❑ No
If yes, ❑ Frequent _____ ❑ Rare _____

❑ **VNS:** ❑ Yes ❑ No
If yes, location of VNS: _____

❑ **Known history or diagnosis of diabetes:** ❑ Yes ❑ No
Watch for & report: _____
_____

❑ **Uses Oxygen: Observe Color/Shortness of Breath**

❑ **Cardiac (Heart) Condition:** Watch for & report: _____
_____

❑ **Respiratory (Breathing) Condition:** Watch for & report: _____
_____

❑ **Ostomy, bladder or other catheter in place.**

❑ **Feeding tube, IV, or other venous line in place.**

❑ **Equipment Transport** – *Specify details*:
What: _____
When: _____

Child's History of Hospitalization/Disease History:

_____
_____
_____
_____
_____
_____
_____
_____

Comments:

_____
_____
_____
_____
_____
_____
_____

Nurse's Signature: _____ Date: _____