

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 #	
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Date of Birth:	Social Security Number:	Medicaid Number:	School District: (Birth to 22 Yrs)	Medicare / Insurance #			
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Additional Agency: (if applicable)		Agency Contact Person: (if applicable)		Agency Phone/cell:			
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Mother/Legal Guardian Name:		Mother/Legal Guardian Address:		Phones:		List to Call	
				Home _____		_____	
				Cell _____		_____	
				Work _____		_____	

Mother Employer's Name (if applicable):							
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Father/Legal Guardian Name:		Father/Legal Guardian Address:		Phones:		List to Call	
				Home _____		_____	
				Cell _____		_____	
				Work _____		_____	

Father Employer's Name (if applicable):							
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List Medical Contacts, In Case of Emergency

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

Authorization of Emergencies:

List 2 Emergency Contacts for use ONLY if parents 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

<p>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.)</p>	<p>Hospital Preference: - Lanes Ambulance will transport to one the following: - CHOOSE ONE</p> <p><input type="checkbox"/> Trumbull <input type="checkbox"/> St. Joe's <input type="checkbox"/> St. Elizabeth – downtown</p> <p><input type="checkbox"/> Akron Children's in Boardman</p>
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Type of Diet: <input type="checkbox"/> Regular <input type="checkbox"/> Other (please name & explain):	Restrictions:
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ADAPTIVE DEVICES USED BY THIS PERSON: Dentures Eyeglasses Braces Splints Orthotics List others:

AMBULATION: Independent Assist Walker Cane

Wheelchair – please circle ****Type of Chair - Manual or Electric / **Type of Seat - Standard or Gel**

COMMUNICATION: Verbal Non-verbal Uses Signs Language Gestures

Signature

Date

**TURN OVER & COMPLETE
BACK SIDE**

PERMISSIONS

I have reviewed and I 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. Thank you.
	<u>PERMISSION TO RELEASE MEDICAL INFORMATION:</u> I hereby give my permission that health/medical/nursing information may be shared with Fairhaven staff, including nursing, transportation, ambulance staff, & emergency medical staff who may need to treat or work with this person.
	<u>TREATING and TRANSPORTING in EMERGENCY SITUATIONS:</u> In all cases, nurses and/or leadership will use their professional judgment and 911 will be contacted 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 fees will be the responsibility of the parent/caregiver/guardian.
	<u>PHOTOS:</u> 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. <input type="checkbox"/> I give my permission for pictures and photos that individually identify students and enrolled adults. <input type="checkbox"/> No, I DO NOT give my permission.
	<u>COMMUNITY PROGRAMMING:</u> Fairhaven will send notification of planned and supervised community programming. <input type="checkbox"/> I give my permission for participation in community programming. <input type="checkbox"/> No, I DO NOT give permission.

Registration Authorization: PRESCHOOL ONLY

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

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

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.

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 _____ Occasional/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* _____

Child's History of Hospitalization / Disease History:

Comments: _____

- Ostomy, bladder or other catheter in place.
- Feeding tube, IV, or other venous line in place.
- Equipment Transport – Specify details:
What: _____
When: _____

Nurse's Signature

Date

NOT APPLICABLE