☐ **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 to 22 Yrs)	Medicare / Insurance #

Additional Agency: (if applicable)	Agency Contact Person: (if applicable)	Agency Phone/cell:

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

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

COMMUNICATION: ☐ Verbal ☐ Non-verbal ☐ Uses Signs Language ☐ Gestures

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2023-2024

School Year

_____ _____

Signature **Date**

TURN OVER & COMPLETE BACK SIDE