ODESSA R-VII SCHOOL DISTRICT EMERGENCY INFORMATION
Please print legibly and use BLUE INK.
Complete reverse side with Health Information

Date Completed: _______
Bus #: ___________
Grade: _________
Teacher/Best __________

SECTION I

Student's Full Name:____ Preferred Name: __________________
Last First Middle

Race(Circle): White, Black, Hispanic, Asian/Island Pacific, Native American, Multi-Racial - ________________& _______________

Social Security #:___________________ (Optional)

Student Cell Phone #:____________________ Date of Birth:______ Gender: Male _____ Female_____

Is there an Order of Protection, Exparte or special court ordered custody documentation? Yes No

***Please explain:**____
Please provide a copy of the legal documentation to our office.

Parent/Guardian and Spouse/Significant Other (Student Primarily resides with)

#1:____ Relationship:__________________
Last First

Address:____ Home Phone: _________________________

City/State/Zip:_______________________________________ County: Lafayette Johnson other ___________

Cell:___________________ Work: ____________________ Email Address: ___________________________________

#2 (Spouse/Significant Other) __________________________________ Relationship: ___________________
Last First

Cell:___________________ Work: ____________________ Email Address:_____________________________________

Parent/Guardian and Spouse/Significant Other (Alternate household)

#3:____ Relationship:__________________
Last First

Address:____ Home Phone: _________________________

City/State/Zip:_______________________________________ County: Lafayette Johnson Other:_______________

Cell:___________________ Work: ____________________ Email Address:_____________________________________

#4 (Spouse-Significant Other) ____________________________________ Relationship: __________________
Last First

Cell:___________________ Work: ____________________ Email Address:_____________________________________

SECTION II

****Odessa R-7 School personnel will not release students to persons under 18 years of age. ****

In an emergency, the Odessa R-7 School District will only release students to the parents/guardians listed in Section I and persons listed in Section II. It is suggested that parents/guardians call the school and update this information as needed. In an emergency or major disaster during school hours, my child may be released to the following persons other than those listed above:

Name:____________________________________Phone:___________________Relationship:____________________

Name:____________________________________Phone:___________________Relationship:____________________

Name:____________________________________Phone:___________________Relationship:____________________

Name:____________________________________Phone:___________________Relationship:____________________

Over and complete reverse side-Health Information Revised 4/1/15

HEALTH INFORMATION - Student's Name ____________________________

Persons to contact for health or illness emergency (list by preference)

1. ______________________________ Phone: ____________________ Relationship: ____________________
Work phone: ____________________
2. ______________________________ Phone: ____________________ Relationship: ____________________
Work phone: ____________________
3. ______________________________ Phone: ____________________ Relationship: ____________________
Work phone: ____________________

Physician: ____ Phone: ____

Preferred Hospital: ____ Phone: ____

MY CHILD HAS THE FOLLOWING HEALTH CONDITIONS. **(Please check those that apply.)**

ASTHMA: Yes ___ No ___ Triggered by: ____
____
mild ___ moderate ___ severe ___
Treatment(s): ____
Comments: ____
____

SEIZURES: Yes ___ No ___ Frequency: ____
Describe seizures: ____
____
Comments: ____
____

DIABETES: Yes ___ No ___ Type I ___ Type II ___
Insulin: ____
Insulin administration will be required during school hours. Yes ___ No ___
When? ______________________________ By whom? ______________________________
Blood glucose monitoring will be required during school hours. Yes ___ No ___
When? ______________________________ By whom? ______________________________

ALLERGIES: Yes ___ No ___ If yes, please list below and circle appropriate description.
Please list: ____________________ mild/moderate/severe ____________________ mild/moderate/severe
____________________ mild/moderate/severe ____________________
mild/moderate/severe
____________________ mild/moderate/severe ____________________
mild/moderate/severe
Comments: ____
____

OTHER HEALTH CONCERNS:
Please list and explain any condition, illness, or past injury that could affect your child's attendance or performance at school. ____
____
____

Does this student need to be seated near the front of a classroom due to vision, hearing, or health concerns?
Yes ___ No ___ If yes, please explain: ____
____

MEDICATION TAKEN AT:
Home: ______________________________ School: ______________________________
Reason for taking: ____

Signature: ____**Date:** ____________________
(PARENT/GUARDIAN SIGNATURE)