☐ **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

_____ _____

Signature **Date**

TURN OVER & COMPLETE BACK SIDE

Name: _____

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.
	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, & 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 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.
	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. ☐ **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. ☐ **I give my permission** for participation in community programming. ☐ 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

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.

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

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*
_____
_____ ☐

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

☐ ***NOT APPLICABLE***