

Roots Activity Learning Center, Inc.
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Washington, DC 20011
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Web Address: <http://www.rootsactivitylc.org>

AUTHORIZED STUDENT HEALTH AND EMERGENCY CONTACT INFORMATION

Name _____
Last First Middle (full middle name)

Address _____
No. Street Town Zip code

Home Phone _____ Gender _____ Date of Birth _____

Language spoken at home _____ Place of Birth _____

Does child have health insurance? Yes/Provider _____ No _____

Parent 1/Guardian name (print) _____

Home Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Parent 1 Signature _____

Parent 2/Guardian name (print) _____

Home Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Pager _____

Parent 2 Signature _____

**IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED,
PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.**

EMERGENCY NAME _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Physician's Name _____ Phone _____

Dentist's Name _____ Phone _____

Hospital of Choice _____ (EMT or Paramedic may override choice)

Please check all that applies to your child:

Heart condition _____ Diabetes _____ Asthma _____ SeizureDisorder _____ ADD/ADHD _____ Migraines _____ Depression _____

Other (specify) _____

Allergies (food, insects medication, environment, (specify) _____

Does your child have an EpiPen? Yes _____ No _____

Hearing Problems (specify) right ear _____ left ear _____

Vision Problems (specify) _____

I give my permission for the school nurse to administer Tylenol or ibuprophen to my child.
Parent/Guardian signature _____ Date _____

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral diagnosis and treatment.

Parent/Guardian signature _____ Date _____