Oregon Episcopal School
6300 SW Nicol Road
Portland, OR 97223
Tel: 503-246-7771 Fax: 503-293-1105

Emergency Information Form

Student: ______________ Grade: ________ Birthdate: ______________

Parent/Guardian: ______________

Address: ______________

City: ______________ State: ________ Zip: ________

Home Phone: ______________ Country of Birth ______________

Mother Business Phone: ______________ Alt ______________

Father Business Phone: ______________ Alt ______________

Student Physician: ______________ Physician's Phone: ______________

Student Dentist: ______________ Dentist's Phone: ______________

Student Ophthalmologist: ______________ Ophthalmologist's Phone: ______________

Hospital Preference, If Any: ______________

Health Insurance Carrier: ______________ ID# ________ IDGroup # ________

In the event that the School cannot reach you in case of accident or other emergency, whom do you authorize to grant permission for emergency medical treatment for your child?

Name: ______________ Relationship to Child: ______________

Home Phone: ______________ Business Phone: ______________

Name: ______________ Relationship to Child: ______________

Home Phone: ______________ Business Phone: ______________

If the school is unable to reach you or a person named above, do you give the School permission to authorize emergency care?

Permission Given ________

(Yes/No) *(If permission is not given, this may affect a student's participation in off-campus activities).*

As a parent or legal guardian of a minor born on . I hereby authorize Oregon Episcopal School at my expense to authorize emergency care, take my child to a physician of their choice, and to consent to any x-ray examination, anesthetic, diagnosis, medical or surgical treatment deemed necessary, if I or a person listed above cannot be reached by telephone. I acknowledge that Oregon Episcopal School would not intentionally act negligently and hereby release Oregon Episcopal School from any claims that I might have as a result of any emergency treatment for the above named child. This permission is in effect for the duration of my child's enrollment at Oregon Episcopal School.

Signature: ______________ Date: ________

Ongoing Health Concerns

Asthma? ________ (Yes/No) Symptoms: ______________

Treatment: ______________

Allergies? ________ (Yes/No) Allergies: (specify type) ______________

Symptoms: ______________

Treatment: ______________

Other Conditions: ______________

Prior Head Injury? ________ (Yes/No) Date: ________

Current Medications ______________

Date of last Tetnus Immunization: ______________

Signature: ______________ Date: ________

If any of the above information changes, please notify OES immediately.
This form must be returned before student attends school

Revised: 5/5/2008

Information Revised: