Guam Department of Education
500 Mariner Avenue
Barrigada, GU 96913

Mode of Transportation ☐ Bus Rider ☐ Car Rider ☐ Walker

DEPARTMENT OF EDUCATION

Emergency Information & Health Form (EIHF)

Student Name: _____ **School**: _____
Last First Middle Initial

Date of Birth: ____/____/____ **Male or Female** **Grade**: _____ **Room**: ____ **Ethnicity**: _____
Month Day Year ***(circle one)***

Father/Guardian: _____ Mother/Guardian: _____

Mailing Address: _____ Mailing Address: _____

Home Address: _____ Home Address: _____

Home Phone: _____ Home Phone: _____

Employer/Dept.:_____ Employer/Dept.:_____

WorkPhone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

It is REQUIRED to provide an alternate contact name and number of an adult who can pick your child up from school if you cannot be contacted. All adults will be required to show photo identification when picking up your child. Students will be released ONLY to those listed below.

	Name	Relationship to Child	Home Phone	Work Phone	Cell Phone
1					
2					
3					
4					

In the event of a food borne illness, DOE/DPHSS are authorized to obtain stool/vomit samples from the child in the interest of Public Health. [☐] Yes [☐] No

I give permission for the ambulance to transport my child to [☐] GMH [☐] Naval Hospital
☐ GRMC Insurance:_____

In case of an Emergency, DOE Reserves the Right to release contact information to your child's bus driver or the Superintendent of Operations, Department of Public Works.

My child is able to participate in regular PE class. [☐] Yes [☐] No If "NO" a Health Care Provider clearance is required

Parent's Signature: _____ **Date:** _____

Basic Health Data

(To be filled out by Parent/Guardian(s) to effectively meet the health needs of your child at school.)

Yes	No	Complete checklist below regarding your Child
		Rheumatic Fever
		Diabetes
		Heart Disease
		Skin Problems [ ] Eczema [ ] Other
		Seizures Date of last seizure:
		Hearing Problem Hearing Aid: [ ] Yes [ ] No
		Vision Problem [ ] Glasses or Contact Lenses [ ]
		Asthma [ ] Inhaler [ ] Nebulizer Date of last asthma attack:
		Allergy to: [ ] Food [ ] Drugs [ ] Other; specify:
		Allergy to: [ ] Bee Sting [ ] Insect Bite Type of reaction:
		Epipen [ ] Yes [ ] No ER visit for reaction [ ] Yes [ ] No
		Current Medication(s): Reason:
		Other Serious Illness or Injury:
		Other Physical or Mental Problems or Concerns:

(Please Draw a Map to your Residence)

List the names of all your children who are attending this school (including Head Start) from the oldest to the youngest.

	Child's Name	Grade	Room
1			
2			
3			
4			
5			