SECONDARY

*Please complete both sides of this card. Print legibly using **black ink** only.*

2025-2026

EMERGENCY CONTACT INFORMATION

FIRST BAPTIST SCHOOL
14400 Diamond Path West, Rosemount, MN 55068
651-423-2272 fbsrosemount.org

STUDENT'S LAST NAME _____ FIRST _____ MIDDLE

☐ Male ☐ Female Date of Birth _____ (MM / DD / YYYY) Grade _____

PRIMARY ADDRESS OF STUDENT: Street Address: _____

City: _____ State: _____ Zip code: _____

PARENT OR GUARDIAN #1 (this is the parent or guardian who is to be the initial contact in case of an illness or emergency):

FIRST & LAST NAME: _____ Email: _____ Cell phone: _____

PARENT OR GUARDIAN #2:

FIRST & LAST NAME: _____ Email: _____ Cell phone: _____

EMERGENCY CONTACTS IN CASE A PARENT/GUARDIAN CANNOT BE REACHED:

1. NAME: _____ Relationship to student: _____ Cell phone: _____

2. NAME: _____ Relationship to student: _____ Cell phone: _____

MEDICAL INFORMATION FOR THIS STUDENT (circle YES or NO to answer each question):

1. Does this student have any severe/life-threatening allergies (ex: bee stings, peanuts, shellfish, etc.)? YES NO If yes, please provide complete details: _____

2. Does this student have any significant health concerns (ex: diabetes, seizures, etc.) -AND/OR- does this student currently take any prescription medication? YES NO
If yes, please provide complete details: _____

3. Does this student require prescription medication to be kept in the school office and given during school hours (this includes emergency medications such as an EpiPen, inhaler, etc., as well as any other doctor-prescribed medication)? YES NO If yes, please list medication(s) and dosage(s) as well as the reason for the prescription(s):

_____

***Please note that a signed doctor's order is required for the school nurse or office staff to be able to administer prescription medication to your student. ***

FBS OFFICE STAFF HAS PERMISSION TO ADMINISTER TO THIS STUDENT FOR PAIN/FEVER:

YES NO
☐ ☐ acetaminophen (Tylenol)
☐ ☐ ibuprofen (Motrin)

I understand that it is my responsibility to keep all of the information on this card up-to-date. I understand that a new card must be completed for every student at the beginning of each school year. I understand that I must complete a new card if there are any significant changes to my child's health during the year.

I understand that it is my responsibility to make arrangements to pick up and care for my child if he/she becomes too ill to remain at school.

I understand that, if deemed necessary by the school nurse or by school officials, emergency 911 personnel may be called to provide care for my child in the case of a serious illness or emergency. Information provided on this card may be shared with law enforcement personnel, paramedics, doctors, or nurses in the event of a medical emergency.

Signature of Parent/Guardian: _____ **Date:** _____

FOR **SECONDARY STUDENTS** ONLY

POLICY FOR SELF-CARRY AND SELF-ADMINISTRATION OF **NON-PRESCRIPTION PAIN RELIEF MEDICATION**

Secondary students (6th through 12th grades only) may have parental permission to self-carry and to self-administer non-prescription pain relief medication at First Baptist School subject to parents understanding and agreeing with the following conditions:

- I understand that the medication must always be kept in its original container.
- I understand that I, the parent, am responsible for determining that my student is knowledgeable in the proper dosage, use, and administration of this medication in a manner consistent with its labeling.
- I understand that pain relief medications are the only type of non-prescription medication that a student may self-carry and self-administer at school.
- I understand that my student may not possess pain relievers containing ephedrine or pseudoephedrine at any time on school premises.
- **I understand that my student may not under any circumstances share medication with any other student.**

By signing below, I give permission for my secondary student to self-carry and to self-administer non-prescription pain relief medication at school.

- I understand that all prescription medications must always be checked in with the school nurse with accompanying signed doctor's orders.
- I agree that if school administration determines that any of these conditions have been abused, my student's privilege of self-carrying and/or self-administering non-prescription pain relief medication will be immediately revoked.
- I understand that disciplinary actions may be taken by school administration if my student is found to have shared any type of medication with another student at any time on school premises.

Signature of Parent/Guardian: _____ **Date:** _____