2019-2020 Health/Emergency Contact Information

Student's Name

Student's Date of Birth

Street Address

City Zip

Home Phone #

Cell Phone #

Mother's Name

Mother's Place of Employment Phone #

Father's Name

Father's Place of Employment Phone #

Doctor's Name Phone #

Insurance Carrier/Medicaid Policy #

In case of illness or injury when I cannot be contacted by the school authorities, I authorize the following relatives or friends to be contacted. In case of emergency, I agree to assume all expenses for moving and medically treating this student. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia which may be carried out based on the medical judgment of the attending physician. The school will continue to call the parents, guardians, or physician until one is reached.

Parent/ Guardian Signature

List the names of emergency contacts who have permission to pick up your child.

Name_____ Relationship _____

Home # _____ Cell # _____

Name_____ Relationship _____

Home # _____ Cell # _____

Are there any restrictions as to who may pick up your child? If yes, list names.

_____

_____

Please note that we may ask to see a driver's license for verification.

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? PLEASE EXPLAIN BELOW.

Asthma_____ Migraines _____ Severe Headaches_____
Allergies_____ Heart Condition _____ Speech Defects _____
Epilepsy_____ Diabetes _____ Vision Loss _____
Emotional Problems_____ Kidney Disorder_____ Inhaler_____
Hearing Loss_____ Medications _____

Birth Defects or Deformities? _____
Is your child under the care of a physician at present? _____
Is your child on any medication that is taken on a regular basis? _____
DATE OF LAST TETANUS BOOSTER _____

Explain any of the above here:

_____

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