

Emergency Card

Currently Assigned Staff:

Student Name:	Gender:	Grade:	Birthdate:	Age:	Student ID#:
Physical Street Address:	City:		State:	Zip:	
Mailing Address:	City:		State:	Zip:	

Parent/Guardian

Parent/Guardian Name:	Relationship:
Address:	Home Phone:
	Cell Phone:
	Work Phone:
	Email:
Parent/Guardian Name:	Relationship:
Address:	Home Phone:
	Cell Phone:
	Work Phone:
	Email:
Person(s) authorized to pickup student from school:	
Custody issue regarding the student:	
Legal restrictions for any parent:	

Emergency Contacts

(Relatives/neighbors/friends who will assume temporary care of your child if you cannot be reached)

Contact 1 Name:	Relationship to student:	Phone Number 1:	Phone Number 2:
Contact 2 Name:	Relationship to student:	Phone Number 1:	Phone Number 2:

Other Children in Family

Name	Gender	Year Born	School Currently Attending	over 18	Relationship to student

Health Information

Medications taken by student at home (written authorization from doctor required for school to administer):

Other Health Condition:

What action is to be taken if student has a complication due to his/her allergic condition or other health condition (Please be specific):

Known Conditions: (check all that apply)

Asthma Bee Sting Allergy Diabetes Epilepsy Heart Condition Seizures	Known hearing problem Preferential seating Wears hearing aid	Glasses to be worn at all times Known eye condition/defect in vision Wears contact lenses Wears glasses
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Insurance

Health Insurance Carrier:	Insurance ID or Policy #:	Hospital Preference
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Physician

Name of Physician:	Address:	Phone:
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Vision (list Dr):

Hearing (list Dr):

Parent Signature

In case of accident or other emergency, if parent or guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation.

Under such circumstances, I further authorize the physician named above to undertake such acts and treatment of my child as he/she considers necessary. In the event said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

I certify that all of the statements and information given above are true and correct to the best of my knowledge:

The undersigned hereby agree to bear all costs incurred as a result of the foregoing. This authorization will remain in effect until revoked by the undersigned in writing:

Signature of Parent or Guardian: _____ Date: _____