Emergency Information Form

Student Name_____ **Grade**_____
Last First

Mother's Name_____ **First Number to Call**_____ **2nd Number**_____

Father's Name_____ **First Number to Call**_____ **2nd Number**_____

Marital Status Married___ Divorced___ Separated___ Widowed___

Please list two nearby relatives/friends who will assume temporary care of you child if you cannot be reached.

Name_____ **Relation**_____

Address_____ _____

First Number to Call_____ **2nd Number**_____

Name_____ **Relation**_____

Address_____

First Number to Call _____ **2nd Number** _____

Is your child under a physician's care for any health conditions which may require emergency action while at school? (Ex: Diabetes, Epilepsy, Asthma, Bleeding Problems, Insect stings, Allergies, to Peanuts, other nuts, other foods or food additives, etc.) **NO** **YES**

If yes, please explain, including symptoms, medications and dosages_____

_____

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In case of an accident or serious illness, I request the school to contact me or persons named on this form. If the school is unable to contact me or other persons named, I hereby authorize the school to contact the physicians indicated below and authorize him/her to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event parents, other persons named and the physicians cannot be reached, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child. I will not hold the school financially responsible for the emergency care and/or transportation for said child.

Physician_____ **Phone**_____

Dentist_____ **Phone**_____

Hospital_____ **Phone**_____

Parent/Guardian Signature_____ **Date**_____

Reviewed: No Change – please initial and date