

EMERGENCY CONTACT FORM 2019-2020

STUDENT'S LAST NAME	FIRST NAME	NICKNAME	SEX	BIRTH DATE
ADDRESS		CITY	ZIP	
HOME PHONE	CELL PHONE PARENT 1		CELL PHONE PARENT 2	
E-MAIL PARENT 1		E-MAIL PARENT 2		
PARENT 1 _____		WORK PHONE _____		
PARENT 2 _____		WORK PHONE _____		
PEDIATRICIAN _____		PHONE _____		

ALTERNATIVE CONTACTS IN CASE OF EMERGENCY

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

HEALTH INSURANCE INFORMATION

Insurance Company Name _____

Phone Number _____ Policy Number _____

SPECIAL MEDICAL PROBLEMS, CHRONIC CONDITIONS, ETC.

ALLERGIES (DRUGS, FOOD, INSECT BITES, ETC.)

MEDICATIONS TAKEN REGULARLY

Name of Medication _____ Reason Taken _____ Dose & Frequency _____

HOSPITALIZATIONS, SURGERIES, MAJOR INJURIES

Nature _____ Date _____ Doctor _____

TREATMENT RELEASE

In the event of a medical emergency involving my child _____ when neither parent can be contacted, I hereby give permission for the School Director or the child's teacher to authorize emergency treatment and release the information given above.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____