



Student Emergency Information

This form shall be filled out each September and returned to school on the first day. Please type or print

Student Name: _____ Date of Birth: _____

Street Address: _____ Grade: _____

City, State Zip: _____ Academic year: _____ / _____

Home phone: _____ Emergency Phone: _____

Father's name: _____ Work phone: _____

Cell phone: _____

Mother's's name: _____ Work phone: _____

Cell phone: _____

List the names of at least two persons who can be contacted if the parents cannot be reached in case of an emergency or illness:

1. Name: _____ Phone Number: _____

Relationship to child: _____

2. Name: _____ Phone Number: _____

Relationship to child: _____

Physician's Name: _____ Phone Number: _____

List any allergies: _____

List any health/medical problems: _____

List medication/drugs taken regularly _____

In the event of an emergency and one of the person's listed on the form are available, I authorize the school to take my child to the hospital or doctor's office for emergency care.

Parent/Guardian signature: _____

Relationship to child: _____

Date: _____

Please return the form to the teacher on the first day of school