

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT TO THE PUPIL AND IN THE EVENT THE PARENT/S CANNOT BE REACHED, PLEASE INDICATE BELOW THE NAME AND PHONE NUMBERS OF TWO PERSONS WHO COULD PICK UP AND TAKE HOME YOUR CHILD IN A TIMELY MANNER. THE SCHOOL IS AUTHORIZED TO PROCEED AS INDICATED BELOW. (PLEASE LIST AS 1,2 IN ORDER OF DESIRED CONTACT)

1. NAME _____ RELATION TO CHILD _____
LAST FIRST

HOME PHONE _____ CELL # _____ WORK # _____

2. NAME _____ RELATION TO CHILD _____
LAST FIRST

HOME PHONE _____ CELL # _____ WORK # _____

CHILD'S PHYSICIAN OR SOURCE OF HEALTH CARE _____ PHONE # _____

CHILD'S DENTIST _____ PHONE # _____

DOES YOUR CHILD HAVE SCHOOL INSURANCE _____ YES _____ NO

HEALTH INFORMATION

Complete the following items, as appropriate, if your child has a condition(s) of which you want us to be aware of.

Child's Name _____ Birth Date _____

Medical Conditions(s) _____

Medications currently being taken by your child _____

Allergies/Reactions _____

Food Allergy _____ Medicine _____ Other _____

(PLEASE LIST WHAT YOUR CHILD IS ALLERGIC TO)

EMERGENCY MEDICAL INSTRUCTION (IF APPLICABLE)

- 1. Signs/symptoms to look for _____
- 2. If signs/symptoms appear, do this: _____
- 3. To prevent incidents: _____

In **EMERGENCIES** requiring immediate medical attention, your child will be taken to the **NEAREST HOSPITAL EMERGENCY ROOM**. Your signature authorizes the responsible person at your child's school to have your child transported to the hospital. I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE

DATE: _____

Parent/Guardian (PLEASE PRINT)

Signature of Parent/Guardian