EMERGENCY INFORMATION RECORD

STUDENT LAST NAME:	STUDENT FIRST NAME:	DATE OF BIRTH:

PARENT/GUARDIAN NAME:	HOME PHONE:

HOME STREET ADDRESS, CITY, STATE, ZIP:

ALTERNATE HOME ADDRESS, CITY, STATE, ZIP:	ALTERNATE PHONE:

MOTHER'S BUSINESS PHONE:	MOTHER'S CELL PHONE:	FATHER'S BUSINESS PHONE:	FATHER'S CELL PHONE:

EMAIL ADDRESS:

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE, CONTACT:

NAME, ADDRESS, PHONE:

NAME, ADDRESS, PHONE:

STUDENT PHYSICIAN - NAME, ADDRESS:	PHONE:

STUDENT DENTIST - NAME, ADDRESS:	PHONE:

HOSPITAL WHERE STUDENT SHOULD BE TAKEN IF PARENT OR PHYSICIAN IS UNAVAILABLE:

ALLERGIES AND OTHER MEDICAL CONDITIONS: (PLEASE EXPLAIN CHECKED ITEMS BELOW)

☐ ALLERGIES	☐ ASTHMA	☐ DIABETES	☐ OTHER
☐ EPILEPSY	☐ HEART PROBLEMS	☐ RECURRING ILLNESS	☐ ADHD/LEARNING DISABILITIES

PARENT: *USE BACK OF CARD FOR ADDITIONAL COMMENTS, IF NEEDED*	In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may take whatever arrangements seem necessary.

PARENT SIGNATURE: _____ DATE: _____