

## EMERGENCY INFORMATION CARD

**PLEASE PRINT**

**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Custodial Parent**  Yes  No

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**E-mail address** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Custodial Parent**  Yes  No

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**E-mail address** \_\_\_\_\_

**In case of accident or illness, I request the school to contact me first. If the school is unable to reach me, I hereby authorize the school to contact the following people to pick up my child and make any decision necessary for the welfare of my child.**

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Physician's Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Dentist's Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Hospital Preference** \_\_\_\_\_

**Please list all medications the child is taking** \_\_\_\_\_

**Allergies** \_\_\_\_\_

**Special Health Concerns** \_\_\_\_\_

**Signature of Parent or Guardian** \_\_\_\_\_

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**Student's Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Custodial Parent**  Yes  No

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**E-mail address** \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Custodial Parent**  Yes  No

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

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**Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Relationship** \_\_\_\_\_

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

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**Dentist's Name** \_\_\_\_\_ **Ph one** \_\_\_\_\_

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