STUDENT MEDICAL/ EMERGENCY INFORMATION

Please complete and return. A separate sheet for each child is requested to ensure clear communication of medical and emergency information.

Student's Name: _____ Grade: _____

Date of Birth: _____ SS#: _____ Male/Female:_____

Mother's Name: _____ Home Phone:_____

Cell Phone: _____ Other: _____ Work Phone: _____

Place of Employment: _____

Father's Name: _____ Home Phone:_____

Cell Phone: _____ Other: _____ Work Phone: _____

Place of Employment: _____

Emergency Contact 1: _____ Phone: _____
Name and relationship to student

Emergency Contact 2: _____ Phone: _____
Name and relationship to student

Authorized to Pick up Student: _____

Insurance Verification

Health/ Accident Insurer: _____ Policy #_____

Emergency Information and Medical Treatment Consent

I, _____ the parent or guardian of, _____recognize that as a result of participation in student activities, medical treatment. on an emergency basis Il*lay be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance.

*Please make the following notations on my child's records:

Allergies: (list all allergies including food and medication)

Medications for long-term illness: (Indicate illness and medication)

Illness	Medication

Date: _____ Signature: _____