STUDENT EMERGENCY CARE FORM

Student's Last Name	First	MI

Date of Birth	Age	Sex	Grade	SS #

Father's Name _____

Address_____ City_____ Zip_____

Phone: Home _____ Work _____ Cell _____

Mother's Name _____

Address _____ City _____ Zip _____

Phone: Home _____ Work _____ Cell_____

E-Mail _____

Person(s) To Call In Emergency When Parents Cannot Be Reached:

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Name _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Family Physician _____ Phone _____

Choice of Hospital _____ Insurance Co. _____

Has child any drug/food/environmental/etc. allergies: _____

Any additional medical information: _____

List daily medications: _____ Date of latest DT: _____

If any emergency arises, the school will try to contact the student's mother or father. If neither of these can be reached, I give permission to Dr. _____ to be wholly responsible for the care of my child. If he is unavailable in the event of a major emergency, the administration is directed to seek emergency care at the medical or hospital facility indicated above. I will be responsible for the payment of all expenses incurred.

_____ _____

Signature of Parent or Guardian Date