

EMERGENCY INFORMATION ~ FOR THE: 20_____ – 20_____ SCHOOL YEAR

Please fill out this form completely – for example, if your child has no allergies, write “None” in the space provided. Thank you.

Student’s LEGAL Name: Last: _____ First: _____ Middle: _____ **Gender:** Male / Female

Student’s Address: _____ **City & Zip:** _____ **Mobile #:** _____

Child resides with: Both Parents Mother only Father only Other/specify _____ (Documentation Required)

Birth Date: _____ **Nickname:** _____ **Grade in School:** _____ **School District:** _____

Mother’s Full Name: _____ **Address:** _____

City: _____ **Zip Code:** _____ **Home #:** _____ **Mobile #:** _____

Work #: _____ **E-Mail:** _____

Father’s Full Name: _____ **Address:** _____

City: _____ **Zip Code:** _____ **Home #:** _____ **Mobile #:** _____

Work #: _____ **E-Mail:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone #:** _____

Primary Physician’s Name: _____ **Phone #:** _____

Dentist’s Name: _____ **Phone #:** _____

List any Medical Problems: _____

Medications @ Home (Name/Time/Dosage): _____

Medications @ School (Name/Time/Dosage): _____

Special Instructions: _____ **Allergies:** _____

Language(s) Spoken in Home, if Other than English: _____

Other Children in the Home & Their Ages: _____

*****OVER *****

If neither parent/guardian can be contacted in case of serious injury or illness, I authorize the school to take any such emergency action as deemed necessary, including transportation to a hospital or medical center.

In providing the above named "Emergency Contacts", I am authorizing communication with these contacts regarding my child's needs in the case of an emergency, illness, injury, or lack of person at home to receive child from transportation. I also authorize these individuals to pick up my child from school if I cannot do so.

Signature of Parent/Guardian

Date

OUTSIDE AGENCIES:

- Is the Student presently seeing a **Therapist** (outside of school)? Yes No / If "Yes" please specify the following:

Name of Therapist: _____ Address: _____

City: _____ Zip Code: _____ Phone #: _____ Fax #: _____

Do we have permission to contact this Therapist? Yes No / If "Yes" please complete a "**Release of Information**" Form.

- Is the Student presently seeing a **Psychiatrist**? Yes No / If "Yes" please specify the following:

Name of Psychiatrist: _____ Address: _____

City: _____ Zip Code: _____ Phone #: _____ Fax #: _____

Do we have permission to contact this Psychiatrist? Yes No / If "Yes" please complete a "**Release of Information**" Form.

- Is the Student presently involved in the **Courts**? Yes No

- Is the Student presently involved with a **Probation Officer**? Yes No / If "Yes" please specify the following:

Name of Probation Officer: _____ Address: _____

City: _____ Zip Code: _____ Phone #: _____ Fax #: _____

Do we have permission to contact this Probation Officer? Yes No / If "Yes" please complete a "**Release of Information**" Form.

INSURANCE INFORMATION:

Name of Insurance Company: _____ Address: _____

City: _____ Zip Code: _____ Phone #: _____ Fax #: _____

Policy Holder's Name: _____ Birth Date: _____ S.S.#: _____

Group/Policy Number: _____ Employer: _____