

# EMERGENCY INFORMATION

(2008-2009 School Year)

Student's LEGAL Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ Gender: Male / Female

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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 #: \_\_\_\_\_

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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 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: \_\_\_\_\_