



Emergency Information Card 07/08

Date _____

Student Name _____

DOB _____

Allergies / Major Health Conditions / Current Medication:

This is required information; do not leave blank, write none if not applicable.*

If your child requires medication at school, your doctor must complete an administration of medication form which is available from the office or can be downloaded from our website.

Emergency Contact Information:

Blood Type (If Known) _____

Mother / Guardian: _____

Home Phone _____ Work _____ Cell _____

Father / Guardian: _____

Home Phone _____ Work _____ Cell _____

If Neither Parent/Guardian Can Be Reached, List Two Other Contacts Who Are Authorized To Act On Your Behalf.

Name _____ Relationship _____

Home Phone _____ Work _____ Cell _____

Name _____ Relationship _____

Home Phone _____ Work _____ Cell _____

Family Physician/Pediatrician _____ Phone _____

Address _____

Dentist _____ Phone _____

Insurance Provider _____

Member or Group # _____ Phone _____

Signature _____

Date _____

(Parent Or Guardian)

Name (printed) _____

**Please note that Protected Health Information may be disclosed to faculty or staff if such information about allergies or other significant medical conditions is required in order to promote students' health and safety.*