## Emergency Card

Currently Assigned Staff:

| Student Name: | Gender: | Grade: | Birthdate: | Age: | Student ID#: |
|---|---|---|---|---|---|
| Physical Street Address: | City: | | | State: | Zip: |
| Mailing Address: | City: | | | State: | Zip: |

## Parent/Guardian

| Parent/Guardian Name: | Relationship: |
|---|---|
| Address: | Home Phone: |
| | Cell Phone: |
| | Work Phone: |
| | Email: |
| Parent/Guardian Name: | Relationship: |
| Address: | Home Phone: |
| | Cell Phone: |
| | Work Phone: |
| | Email: |
| Person(s) authorized to pickup student from school: | |
| Custody issue regarding the student: | |
| Legal restrictions for any parent: | |

## Emergency Contacts

(Relatives/neighbors/friends who will assume temporary care of your child if you cannot be reached)

| Contact 1 Name: | Relationship to student: | Phone Number 1: | Phone Number 2: |
|---|---|---|---|
| Contact 2 Name: | Relationship to student: | Phone Number 1: | Phone Number 2: |

## Other Children in Family

| Name | Gender | Year Born | School Currently Attending | over 18 | Relationship to student |
|---|---|---|---|---|---|
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |
| | | | | ☐ | |

## Health Information

| Medications taken by student at School or at Home (written authorization from doctor required for medications taken at school): |
|---|
| Other Health Condition: |
| What action is to be taken if student has a complication due to his/her allergic condition or other health condition (Please be specific): |

## Known Conditions: (check all that apply)

| | | |
|---|---|---|
| ☐ Asthma | ☐ Known hearing problem | ☐ Glasses to be worn at all times |
| ☐ Bee Sting Allergy | ☐ Preferential seating | ☐ Known eye condition/defect in vision |
| ☐ Diabetes | ☐ Wears hearing aid | ☐ Wears contact lenses |
| ☐ Epilepsy | | ☐ Wears glasses |
| ☐ Heart Condition | | |
| ☐ Nut Allergy | | |
| ☐ Seizures | | |
| ☐ Other (Please Specify Below) | | |

## Insurance

| Health Insurance Carrier: | Insurance ID or Policy #: | Hospital Preference |
|---|---|---|
| | | |

## Physician

| Name of Physician: | Address: | Phone: |
|---|---|---|
| Vision (list Dr): | | |
| Hearing (list Dr): | | |

## Parent Signature

*In case of accident or other emergency, if parent or guardian cannot be reached, I hereby authorize a representative of the school to make such arrangements as he/she considers necessary for my child to receive medical or hospital care, including necessary transportation.*

*Under such circumstances, I further authorize the physician named above to undertake such acts and treatment of my child as he/she considers necessary. In the event said doctor is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.*

*I certify that all of the statements and information given above are true and correct to the best of my knowledge:*

The undersigned hereby agree to bear all costs incurred as a result or the forgoing. This authorization will remain in effect until revoked by the undersigned in writing:

Signature of Parent or Guardian: _________________________________________ Date:________________________