



STUDENT EMERGENCY INFORMATION 2010-2011

Student Name: _____ Grade: _____

Date of Birth: _____ Home Phone: _____

Parent(s) / Guardian(s) Name: _____

Mailing Address: _____

Physical Address: _____

Town of Residence: _____ State: _____ Zip: _____

Father: _____ Place of Employment: _____

Work Phone: _____ Cell Phone: _____ Alternate Phone: _____

E-Mail: _____

Mother: _____ Place of Employment: _____

Work Phone: _____ Cell Phone: _____ Alternate Phone: _____

E-Mail: _____

Whom may we contact **IN TOWN** to transport and/or care for your child if you are not available? Please provide three names:

_____ Phone: _____
_____ Phone: _____
_____ Phone: _____

Please provide the name of your child's:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Insurance Coverage: _____ Policy No: _____

Last physical exam: Date: _____ By: _____

Copy of your child's current immunization records attached? Yes _____ No _____

If no, please explain: _____

Please check (and explain) if your child has:

Allergies ____ Medical Condition ____ Disabilities ____ Other _____

Is your child on any medication? No _____ Yes _____ If yes, please state medication and if it needs to be administered at school. (see med. form)

In the event that your child has a serious illness or accident, the school will use its best judgment in determining if your child should be transported by ambulance to the nearest hospital, while making every effort to reach the parent.

Signature of Parent

Date