**(SCHOOL NAME)**

## EMERGENCY CONTACT FORM - STUDENT ILLNESS PROCEDURE

**PERSONAL DATA**

 Student Name Grade Date of Birth

 Home Address Home Phone Number

 Parent/Guardian 1 Name Parent/Guardian 2 Name

 Phone (Cell) (Other) Phone (Cell) (Other)

**PLACE OF EMPLOYMENT**

 Parent/Guardian 1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Working Hours Work Phone

 Parent/Guardian 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Working Hours Work Phone

**NAME OF LOCAL PERSON TO CONTACT IF PARENTS ARE UNAVAILABLE**

 Name Relationship

 Address Phone (Cell) (Other)

**HEALTH INFORMATION**

Primary Insurance Carrier Primary Insurance Carrier Policy/Group Number

 Doctor/Pediatrician Name Telephone

 Dentist Name Telephone

 Does your child have any unusual health conditions? ❑ Yes ❑ No

 If yes, please indicate:

 ❑ Asthma ❑ Bee Sting Allergy ❑ Internal Irregularities ❑ Deafness ❑ Physical Handicap

 ❑ Kidney/Bladder ❑ Peanut Allergy ❑ Convulsive Seizures ❑ Surgical

 ❑ Arthritis ❑ Other Allergy (list) ❑ Sight Impairment ❑ Fractures ❑ Other

 ❑ Diabetes ❑ Wears Glasses/Contacts ❑ Heart

 Are there any physical or emotional limitations the teacher and staff should consider in working with your child?

 ❑ Yes ❑ No

 If yes, please explain.

 Parent/Guardian Name (Please Print):

 Signature Date

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Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

In the event reasonable attempts to contact me at the above listed phone numbers have been unsuccessful, I hereby give my consent to the administration of emergency medical treatment by any licensed physician or dentist and to transport my child to any reasonably-accessible hospital facility.

Parent/Guardian Name (Please Print):

Parent’s/Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_