

EMERGENCY INFORMATION CARD

Allergies _____

Please Print

Grade _____ Home Room _____

Student's Name _____
LAST FIRST S.S. NO. STUDENT I.D. NO.

Address _____ Zip _____ Home Tel. _____

Where can parent/guardian be reached if not at home? Birth date _____

Mother/Guardian _____
FIRST NAME LAST NAME ADDRESS WORK NO.

Father _____
FIRST NAME LAST NAME ADDRESS WORK NO.

LIST OTHER PHONE NUMBERS: HOME: _____ CELL PHONE: _____ PAGER: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated on reverse side and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

OPTIONAL INFORMATION (Your school may or may not require you to complete)

The following medications may be given:	<input type="checkbox"/> yes	<input type="checkbox"/> no - TYLENOL	<input type="checkbox"/> yes	<input type="checkbox"/> no - IBUPROFEN
<input type="checkbox"/> yes <input type="checkbox"/> no - COUGH DROPS	<input type="checkbox"/> yes	<input type="checkbox"/> no - ROLAIDS	<input type="checkbox"/> yes	<input type="checkbox"/> no - MIDOL

(OVER)

Date _____

Signature of Parent or Guardian _____

List 3 neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

1. Name _____

Address _____ Tel. _____

2. Name _____

Address _____ Tel. _____

3. Name _____

Address _____ Tel. _____

Local Physician's Name _____

Address _____

Office Telephone No. _____ Fax No. _____

(OVER)