



### Emergency Information Form

\_\_\_\_\_  
Last Name                                      First Name                                      ID#                                      DOB                                      Teacher/Grade

\_\_\_\_\_  
Address

\_\_\_\_\_  
Mother/Guardian                                      Home/Cell Number                                      Work Number

\_\_\_\_\_  
Father/Guardian                                      Home/Cell Number                                      Work Number

Insurance Company: \_\_\_\_\_

Type of Coverage: Basic (circle one): Yes No                                      Major Medical (circle one): Yes No

Deductible (optional): \_\_\_\_\_                                      Policy/Group Number (optional): \_\_\_\_\_

Contact Lenses (circle one): Yes No

1. Is your child currently taking any medications prescribed by a doctor (circle one)? Yes No If yes, please list medications and reasons for taking them. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Does your child have any allergic reactions to any type of medication (circle one)? Yes No If yes, please list. \_\_\_\_\_  
\_\_\_\_\_

3. Does your child have any type of medical condition for which we should be notified (circle one)? Yes No If yes, please list. \_\_\_\_\_  
\_\_\_\_\_

### PARENT OF GUARDIAN'S PERMIT

*The parent herewith grants permission for school employees to secure medical services for the above named student if necessary. Permission is hereby granted to the attending physician to proceed with any above named student. In the event of surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student will be given.*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

