Emergency Card
Please print. Please let us know of any changes

Child's Full Name:_____

Male__ Female__ Date of Birth (mm/dd/yy)_____Current Age_____

Students Address:_____

Main Phone #_____

Parent/Guardian Name	Cell Phone	Work Phone	Relationship to Child

Email #1_____#2_____

Emergency Contacts/Pick Up List (Please be sure emergency contacts are local).

Emergency Contact	Address	Phone #	Relationship to Child

Does your child have a problem or physical limitation that you would like us to know about? Yes____ No____

If you checked "Yes" please explain (Ex. Asthma, ADHD, Cardiac Condition, Diabetes, Epilepsy…)

_____

Does your child have a severe allergy?

Yes_____No_____

If Yes, please explain_____

If Yes, how is the allergy treated? (Benadryl, Epi Pen)

_____

Does your child eat a special diet or have dietary restrictions? Yes_____No_____

If Yes, please explain:_____
(feel free to add more info below or on the back)

Does your child have a hearing or vision problem? Yes_____No_____

If Yes, please explain:_____

Hospital Preference:_____

Child's Doctor/Phone Number:_____

I agree that the School Administrator may authorize a physician of his/her choice to provide emergency care in the event that neither I nor the family physician can be contacted immediately.

Date_____Parent/Guardian Signature_____

Date_____Parent/Guardian Signature_____