



Student Emergency Information

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Birth Date: _____

Parent's Name: _____

Parent's Home Phone: _____ Parent's Work Phone: _____

Emergency Contact Information

Full Name: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Hospital Preference: _____

Medical Doctor: _____ Phone # _____

Please check any CURRENT health condition that may require attention during the school day or in an emergency:

- Allergies (be specific)
 - Foods _____ EpiPen __Yes __No
 - Medicines _____
 - Bee Stings EpiPen __Yes __No
 - Other _____
- Asthma
- Cancer
- Diabetes
- Seizures
- Heart problems (be specific) _____
- Physical disability (be specific) _____

List all medications and dosage: _____

Other health conditions (be specific) _____
