Grade_____

Teacher _____

STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Please complete the following information below and return to school immediately.

Student's Name_____
Last First Middle

Address_____

Home Phone (_____)_____

Sex_____ Date of Birth_____/_____/_____ Primary Language_____

Does your child have Health Insurance? _____Yes _____No
Health Insurance Company_____ Policy Number_____

Father (please circle one) biological, step, guardian, adoptive

_____

Home Address_____

Home Phone (_____)_____ Cell (_____)_____
(If different from above)
Work Name _____Work #: (_____)_____Ext. _____

Mother (please circle one) biological, step, guardian, adoptive

_____

Home Address_____

Home Phone (_____)_____ Cell (_____)_____
(If different from above)
Work Name _____Work #: (_____)_____Ext. _____

Name/Grade of sisters/brothers in school building_____

_____

Name of others who will assume responsibility/transportation.

Name_____Relationship_____Daytime Phone (_____)_____

Name_____Relationship_____Daytime Phone (_____)_____

In case of medical emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician Name_____ Phone (_____)_____

Dentist Name_____ Phone (_____)_____

Please list all medications that your child takes for a prescribed condition and name the condition.

_____

_____

Wears glasses___ yes____no nearsighted____ farsighted____ Physician Name_____

Please list any allergies that your child has.

_____

Signature_____Date_____

Print Signature_____