EMERGENCY INFORMATION – 2011-2012

Before Care_____ After Care_____

GRADE (2011-12): ____________ **BIRTHDATE:**_______________ **GENDER** ____**Male** ____**Female**

CHILD'S NAME:______________________ ________________ ____________ ______________

Last First Middle Home Phone

HOME ADDRESS: _____________________ _________________________ __________ ______

Street City State Zip

FATHER'S NAME: __________________________________**PHONE:** H:___________________________

W: ______________________ CELL PHONE:________________EMAIL:________________________________

HOME ADDRESS: : _____________________ _________________________ __________ ______

(If different from child) Street City State Zip

MOTHER'S NAME:__________________________________**PHONE**: H:_________________________

W: ______________________ CELL PHONE:________________EMAIL:________________________________

HOME ADDRESS: : _____________________ _________________________ __________ ______

(If different from child) Street City State Zip

AUTHORIZED PERSONS to assume responsibility for school dismissal and provision of care when parent or guardian cannot be reached. **PLEASE NOTE: STUDENT WILL ONLY BE RELEASED TO PERSONS AUTHORIZED BY PARENT OR GUARDIAN**.

Name:______________________Phone:_______________Cell:________________Relationship:______________

Name:______________________Phone:_______________Cell:________________Relationship:______________

Name:______________________Phone:_______________Cell:________________Relationship:______________

Family Physician or Pediatrician:______________________________**Phone:**_____________________

Family Dentist____ **Phone:** __________________________

Local Hospital Preference:____

Insurance which applies to the child__________________Policy ID:__________Group #:____________

Relevant medical factors including allergies (food, drug & seasonal), medications and physical impairments:

____

____

CONSENT FOR EMERGENCY TRANSPORTATION AND MEDICAL TREATMENT: In the event my child needs to be transported by ambulance or emergency vehicle, I authorize transportation. In the event reasonable attempts to contact me/us have been unsuccessful, I/we hereby give my/our consent for administration of any treatment deemed necessary by Dr. ___________________(preferred doctor) or Dr. _____________(preferred dentist); or, in the event the designated practitioner is not available, by another doctor or dentist; and the transfer of the child to the above-stated hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two (2) other-licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

____ ______________________

Signature of Parent or Guardian Date

(If you need additional space, please use the reverse side)

School Copy