STUDENT EMERGENCY INFORMATION

PLEASE RETURN THIS FORM TO THE NURSE AS SOON AS POSSIBLE

Name _____
Address _____
_____
D.O.B. _____
Grade _____ Sex _____
Teacher _____

Email _____
Tel. No. (home) _____
Mother name _____
cell # _____
work _____
Father name _____
cell # _____
work _____

Physician _____ Phone _____
Dentist _____ Phone _____

Emergency Contact Persons OTHER THAN PARENTS. Please give local numbers and full name of the following adults your child may be released to in case of an emergency.

Last Name/ First Name	Home phone	Cell phone	Relationship

OVER

Has your child had any serious illness, injury or operation during the past year?
Yes_____ No _____

Does your child receive any medication on a regular basis?
Yes _____ No _____

Does your child have Asthma, Diabetes, Epilepsy, a heart or orthopedic condition, or any other medical condition?
Yes_____ No _____

Does your child have any ALLERGIES? _____

Does your child have any vision or hearing problems? _____

Any recent immunizations, tests or had a physical exam in the past year?
_____

Signature of parent/guardian_____ Date_____

HF #56B (4/165)