

PERSONAL DATA & EMERGENCY INFORMATION FORM

Full Name of Pupil _____ Date _____
Last First Middle
Address of Pupil _____
Street/P.O. Box City State Zip
Telephone _____ Date of Birth _____ Grade _____
School _____ Homeroom Teacher _____

TO PARENT OR GUARDIAN: To serve your child in case of accident or sudden illness, it is necessary that you furnish the following information.

Parent(s) or Guardian(s) Name: (circle one) Mr. & Mrs. Mr. Mrs. Ms.

Place of Employment (*Husband/Guardian*) _____ Phone _____
Place of Employment (*Wife/Guardian*) _____ Phone _____
Where do we contact you in case of emergency? _____ Phone _____

If you cannot be reached, please list persons authorized to pick up your child in case of emergency or illness. This person will be required to present proof of identification.

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

In case of emergency and neither you nor the two people listed above can be contacted, which local physician do you wish your child to be taken to?

"I give my permission for _____ to be taken by school nurse or school personnel to M.D./Clinic or health care provider _____ for emergency treatment in the event I cannot be located. I will be responsible for the doctor's fee."

Parent's Signature

Is your child on any routine medication? _____ Yes _____ No
If so, what does he/she take and for what condition _____

Does your child have a history of heart disease, diabetes, T.B., nervous disorder, epilepsy, bee stings, ear infection, seizure activities, asthma, allergies, etc.? Please describe _____

Signature of Parent or Guardian

Date