

HEALTH OFFICE EMERGENCY INFORMATION

STUDENT _____ LAST NAME _____ FIRST NAME _____ SEX _____ STUDENT'S HOME PHONE # _____

GRADE _____ TEACHER _____ DATE ENROLLED _____ BIRTHDATE _____

STUDENT'S ADDRESS _____ PREVIOUS SCHOOL _____

SPECIAL HEALTH CONDITIONS NO YES IF YES, PLEASE LIST: _____

MEDICATION GIVEN AT HOME SCHOOL (IF GIVEN AT SCHOOL A REQUEST FORM IS REQUIRED) PLEASE LIST MEDICATIONS: _____

ALLERGIES NO YES IF YES, PLEASE LIST: _____

GLASSES NO YES CONTACT LENSES NO YES HEARING AIDS/PROBLEMS NO YES

PLEASE TURN OVER

STUDENT'S DOCTOR _____ STUDENT'S DENTIST _____

STUDENT LIVES WITH: MOTHER & FATHER MOTHER FATHER OTHER _____

IF YOUR CHILD BECOMES ILL OR INJURED AT SCHOOL WE SHOULD CONTACT, IN THE FOLLOWING ORDER: (EX. MOTHER, FATHER, RELATIVE, FRIEND, OR NEIGHBOR).

1. _____
NAME HOME #/WORK #/CELL # RELATIONSHIP

2. _____
NAME HOME #/WORK #/CELL # RELATIONSHIP

3. _____
NAME HOME #/WORK #/CELL # RELATIONSHIP

4. _____
NAME HOME #/WORK #/CELL # RELATIONSHIP

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____