HEALTH EMERGENCY CONTACT FORM

Name_____

Student E-mail:_____ Student Phone: _____

Parent E-mail:_____ Parent Phone: _____

Address_____ Apt. #_____
Street Address

_____ _____ _____
City/Town State Zip Code

Person to contact in case of an emergency:

Name_____ Daytime/Cell Phone_____

Relationship_____ Evening Phone_____

Name of family doctor:

_____ Phone_____

Name of two people (other than above) whom the school may call if you are ill or need emergency care:

Name_____ Phone_____

Name_____ Phone_____

Please note any medical condition of which we should be aware:

_____

I give permission to be taken to Lawrence and Memorial Hospital in case of an emergency.

_____ _____
Signature Date

_____ _____
Parent's Signature (for students under 18) Date

Revised 1/10/2019