Emergency Information Form

Student's Name ________________________________ ____________________ __________________
Last Name *First Name* *Middle Initial*

Student's Address _________________________ ___________________ _________ ______________
Street Address/Apt. # *City* *State* *Zip Code*

Student's Age ______ **Date of Birth** ________________ **Student's Phone Number** ____________

Grade ________ **Teacher (Homeroom)/Classroom** _________________________ **Bus #** _________

TO BE COMPLETED BY PARENT/GUARDIAN

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

MOTHER'S NAME ________________________________ _________________ _______________
Last Name *First Name* *Middle Initial*

Home Phone ________________ Cell Phone ___________ Work Phone ___________

Employer ____

FATHER'S NAME ________________________________ _________________ ________________
Last Name *First Name* *Middle Initial*

Home Phone ________________ Cell Phone ___________ Work Phone ___________

Employer ____

OTHER NAME ____________________________________ ___________________ _____________
Last Name *First Name* *Middle Initial*

Home Phone ________________ Cell Phone ___________ Work Phone ___________

Student's Insurance Carrier ____________________________________ Policy # _______________

Family Doctor's Name: ____________________________________ Phone # __________________

Address:____

In case of emergency, accident, or serious illness of the above named student, I request and authorize Boyle Co. schools to take action necessary to maintain the student's health. If school personnel are unable to contact me, I hereby authorize them to release my students health information to Emergency/Hospital personnel and anyone authorized to pick up my child from school or school sponsored activity.

____ ________________________________
Parent/Guardian's Signature *Date*

Is your child on any daily medication? ☐ Yes ☐ No If yes, please list below:

Medication	Dosage

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Is your child allergic to medication(s)? ☐ Yes ☐ No If yes, please specify ________________
____

Is your child allergic to insect bites? ☐ Yes ☐ No If yes, please specify ___________________
____
____

Does your child have food allergies? ☐ Yes ☐ No If yes, please specify ____________________
____

Does your child have a history of: (Check appropriate boxes.)

☐ Heart disease, ☐ Diabetes,
☐ Seizure, ☐ Asthma, ☐ Other (Specify) ______________________________?

If so, please check and describe any special emergency treatment that may be required:

____

Please list any other health conditions that might require emergency medical treatment: ______
____

____ ______________________________
Parent/Guardian's Signature *Date*

Log of Attempts to Contact Parent/Guardian

Date	Time	Phone # Called	Answered?		Person Answering Phone/Response
			Yes	No	

To Be Completed If Student Is Transported

Date of transportation __________________ Time of transportation __________☐ A.M. ☐ P.M.

Destination _____________________________________ Arrival time ________ ☐ A.M. ☐ P.M.

Means of transportation (**Check appropriate box**.)

☐ EMS vehicle ☐ Board-owned vehicle ☐ Private vehicle

If Board-owned vehicle or Private vehicle, list name of driver: ______________________________

Driver is the/a (**Check appropriate box.**)

☐ Parent/guardian ☐ Relative (*Specify*) _____________________
☐ School administrator ☐ Teacher ☐ Other Board employee

Review/Revised:7/23/09