SAUQUOIT VALLEY EMERGENCY/HEALTH INFORMATION

PLEASE FILL IN ALL BLANKS

GRADE: _____ TEACHER: _____ YEAR: _____

Name: _____ Gender: M F Date of Birth: _____

Telephone: _____ Father Cell #: _____ Mother Cell #: _____

Home Address: _____Town: _____ Zip: _____

P.O. Box: _____ Town: _____

Father/Guardian: _____ Phone: _____ **Mother/Guardian**: _____ Phone: _____

Address: _____ Address: _____

E-Mail Address: _____ *E-Mail Address*: _____

Employer: _____Phone: _____ Ext: _____ Employer: _____Phone: _____Ext:_____

Does your child take any medications on a regular basis? Yes No Specify_____

Does your child wear glasses / contact? _____ MD diagnosed allergies _____

Medical History: Has there been any changes in the child's medical history in the past 12 months? Yes No
If yes please describe. _____
_____

Emergency contact name & phone number if parents cannot be reached.

1. _____
2. _____

In the event that the situation requires the immediate service of a doctor, I authorize the following doctor to be engaged for me.
Physician: _____ Phone: _____

This information will be shared, when necessary, for the health and safety of your child with appropriate school personnel.

Parent / Guardian Signature _____ Date: _____