

Freeport Area School District EMERGENCY INFORMATION FORM

Date: _____

STUDENT _____
Last Name First Name Middle Name Grade Sex

Mailing Address _____
Street City Zip

Residence Address _____
(If different from mailing address) Street City Zip

Phone (circle one) listed not listed (_____) _____ - _____ **Race** _____
(Choose one: White; Black; Latino/Hispanic; Asian/Pacific Islander; American Indian/Native Alaskan; Multi-Racial/Ethnic)

Date of Birth _____ / _____ / _____

Bus # AM _____ PM _____ How many miles is the school from your home? _____ Miles

Are you a Butler or Armstrong County resident? (Circle one) **Butler** or **Armstrong**

Does your child receive special education services or have a 504 Plan?(Circle one) **Yes** or **No**

If yes, explain _____

MOTHER (circle one) Mrs. Ms. _____
First Name Last Name Relationship (Guardian, Step-Mother, etc.)

Address _____
Street City Zip (_____) _____ - _____
Telephone Number

Employer _____ Occupation _____

Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Email Address _____

1st Contact _____ 2nd Contact _____

FATHER (circle one) Mr. _____
First Name Last Name Relationship (Guardian, Step-Father, etc.)

Address _____
Street City Zip (_____) _____ - _____
Telephone Number

Employer _____ Occupation _____

Work Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Email Address _____

1st Contact _____ 2nd Contact _____

Name(s) of Sisters/Brothers	Date of Birth	School Now Attending	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(1) Emergency contact if parent(s) cannot be reached:

First Name Last Name Relationship to Student
Phone Number (____) ____ - _____ Cell Phone (____) ____ - _____
Street _____ City _____ Zip _____

(2) Emergency contact if parent(s) cannot be reached:

First Name Last Name Relationship to Student
Phone Number (____) ____ - _____ Cell Phone (____) ____ - _____
Street _____ City _____ Zip _____

Does your child have any medical problem which you wish to call to the attention of the school? ___Yes ___NO

Student's Special Medical Alert _____
(Allergies, asthma, etc.)

Physician _____ Phone Number (____) ____ - _____

Dentist _____ Phone _____

In the case of accident or serious illness, I request the school contact me. If the school is unable to reach me or the above named people, or the situation demands immediate medical attention beyond that covered by school policy, I hereby authorize the school to arrange to have my child taken to the Emergency Room of the nearest available hospital by ambulance as may be required. Once admitted to the Emergency Room, I give my permission for necessary medical/surgical care to begin immediately for my child.

Signature