

**VISIONS UNLIMITED**  
**STUDENT EMERGENCY INFORMATION**

**2022-23 SCHOOL YEAR**

Birthdate: \_\_\_\_\_

Student Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (zip)

**Please indicate the FIRST telephone number we should call in the event of an emergency:**

\_\_\_\_\_  
Telephone Number Contact Name

**Please list the student's parents, stepparents, guardians that child lives with. State relationship where applicable (i.e., father, stepmother, guardian\*). \*Guardianship papers must be on file in office.**

**Student Lives With:**

1. \_\_\_\_\_  
Last Name First Relationship Place of Employment Day/Cell

2. \_\_\_\_\_  
Last Name First Relationship Place of Employment Day/Cell

**Non-custodial parent information**

Parent \_\_\_\_\_  
Last Name First Number/Street City/Zip Day/Cell

Step-parent \_\_\_\_\_  
Last Name First Number/Street City/Zip Day/Cell

**Neighbors or relatives school may contact in case of emergency if parent/guardian cannot be reached:**

\_\_\_\_\_  
Name Relationship Day/Cell

\_\_\_\_\_  
Name Relationship Day/Cell

**HOSPITAL OF CHOICE (IN CASE OF EMERGENCY):** \_\_\_\_\_

In case of serious illness or accident, if the school is unable to contact me, I hereby authorize the school authorities to use their best judgment on behalf of my child.

**PLEASE FILL OUT BACK OF THIS FORM**

**Health Information**

Particular health problems: e.g., Heart, Kidney, Orthopedic, etc. No \_\_\_\_\_ Yes \_\_\_\_\_ (Please specify) \_\_\_\_\_

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Does student have seizures? No \_\_\_\_\_ Yes \_\_\_\_\_ (If yes, describe likely pattern) \_\_\_\_\_

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Does student have allergies: If yes, please indicate below:

Medicine: \_\_\_\_\_  
Foods: \_\_\_\_\_  
Insects: \_\_\_\_\_  
Pollen: \_\_\_\_\_  
Others: \_\_\_\_\_

**List all medications taken BOTH AT SCHOOL AND HOME**

Name of Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time Administered: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time Administered: \_\_\_\_\_

Name of Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time Administered: \_\_\_\_\_

Attach a list of additional medications, if necessary, including dosage and time administered.

**Date of last physical examination:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Dentist's Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**DATE OF ALL IMMUNIZATIONS** *(If you submitted these records to Visions in the past, no need to send them in again.)*

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Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_