



NURSE'S OFFICE

EMERGENCY CONTACT INFORMATION

Date _____ Grade _____ Birth Date _____

Child's Name _____ Male _____ Female _____
Last First Middle

Street _____ Home Phone _____

City _____ Zip Code _____

Father/Guardian/Other _____ Cell Phone _____

Employed By _____ Work Phone _____

Mother/Guardian/Other _____ Cell Phone _____

Employed By _____ Work Phone _____

E-mail Address: _____

If a 2-parent household, please indicate who should be called first by using a one or a two.

Is it all right to call you at work? Yes _____ No _____

If you do not have a telephone, how can the school get in touch with you? _____

After-School Day Care Provider _____ Phone _____ Cell _____

Address _____

***Persons to be contacted if parents aren't available: Needs to be a local number**

1. Name _____ Relationship _____ Phone _____

2. Name _____ Relationship _____ Phone _____

Doctor's Name _____ Phone _____

Dentist's Name _____ Phone _____

This child has the following medical conditions that you should be aware of (i.e., Allergies, diabetes, epilepsy, heart murmur, etc.): _____

In the event the above named student is hurt or becomes ill at school and needs emergency care, I give the school authorities permission to call a physician or arrange emergency transportation to take him/her to the hospital emergency room and will accept responsibility for any expenses incurred.

Signature of Parent or Guardian

FOR YOUR CHILD'S SAFETY, please notify the office of any change in emergency information. It is important that our information is current. 10/08