

PORT NECHES-GROVES INDEPENDENT SCHOOL DISTRICT
2026-2027 Student Emergency Information

Please complete the following emergency information for your child and make any changes:

School: _____ Teacher: _____ Year: _____ Grade: _____

Student Name _____ SS# _____
Last Name First Name Middle Name

Student Address: _____

Student Lives With: _____ Child's Date of Birth: _____

Father's Name: _____ Mother's Name: _____

Home Phone: _____ Home Phone: _____

Business Phone: _____ Business Phone: _____

Cell Phone/Pager: _____ Cell Phone/Pager: _____

E-Mail: _____ E-Mail: _____

Relative or friend who you designate to pick up your child. List three (*Each having a different phone number*):

Name _____ Relationship _____ Phone _____ Cell _____

Name _____ Relationship _____ Phone _____ Cell _____

Name _____ Relationship _____ Phone _____ Cell _____

Check if your child has any of the following health conditions:

- | | | | |
|---|---|--|--|
| ☐ Abnormal Tendency to Bleed | ☐ Wears Contact Lenses | ☐ Epilepsy/Seizures | ☐ Diabetes |
| ☐ Heart Conditions | ☐ Wear Eye Glasses | ☐ Asthma | ☐ ADD or ADHD |
| | | | ☐ Kidney Disorder |

Other Concerns (list) _____

Allergies (list) _____

Drug Allergies (list) _____

Daily Medication (list) _____

Comments: _____

AUTHORIZATION FOR TREATMENT

In case of accident or serious illness or if emergency treatment is required, may the school authorities use their own judgment in sending the child to the hospital and having emergency treatment before parents are reached? The parent will be responsible for all expenses. Authorization **MUST** be given in order for your child to participate and attend school-sponsored field trips.

YES _____ NO _____ SIGNED _____ Date _____
(Parent or Guardian)

Physician's Name _____

Name of Insurance Company _____

Hospital Preference _____