



2017-2018 EMERGENCY INFORMATION

It is **IMPORTANT** that we have correct, up-to-date information on record for all of our students.

Student Last Name: _____ First Name: _____ Grade _____ Date of Birth _____

Address: _____ 2. _____
(Number) (Street)

_____ 3. _____
(City) (Zip Code)

If student does not reside with both parents, please indicate if non-residential parent requests mailings.

Parent Name: _____ Address: _____

Home Phone#: _____ **E-Mail Address:** _____

Mom's cell phone#: _____ Dad's cell phone#: _____

Father's Name: _____ Employer Name _____
and address: _____

Occupation: _____ Work Phone#: _____

Mother's Name: _____ Employer Name _____
(maiden) and address: _____

Occupation: _____ Work Phone#: _____

Guardian of Child(ren) (Please Circle One)

Both Parents Father Mother Other (Please indicate) _____

Persons authorized to pick up child/ren:

1. Name: _____ Phone#: _____

Address: _____ Relationship to Child: _____

2. Name: _____ Phone#: _____

Address: _____ Relationship to Child: _____

Ethnic Origin: ___Asian ___Black ___Hispanic ___Multi Racial
 ___Native America ___White ___Other (Please list)

Students Religion _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach us, I hereby authorize the school to call the physician or dentist indicated and to follow his instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

SIGNATURE OF PARENT OR GUARDIAN: _____

MEDICAL INFORMATION

Doctor's Name: _____

Dentist's Name: _____

Medical History: Please indicate if the student has any significant medical problems, i.e. asthma, heart condition, etc. _____

Please indicate which child/ren has the allergy/medical condition.

Child 1

Child 2

Child 3

Allergies: Bee stings _____
 Dairy _____
 Penicillin/medications _____
 Peanuts _____
 Dust/mold _____
 Other _____

Remarks: _____
