

EMERGENCY CARD

(Please review information below, complete and update as needed in blue ink)

Student's Name: \_\_\_\_\_ Teacher: \_\_\_\_\_  
(Last) (First) (Middle)

Grade: \_\_\_\_\_ School: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Gender: \_\_\_\_\_

Student lives with: (check all that apply)

- Both Parents  Father  Mother  Step Father  Step Mother  Foster parent(s)  Legal Guardian(s)

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City: \_\_\_\_\_ ZipCode: \_\_\_\_\_ Email Address: \_\_\_\_\_

Neighbor, Relative, Friend authorized to take pupil from school if parent/guardian cannot be located:

1) \_\_\_\_\_ Phone: \_\_\_\_\_ 2) \_\_\_\_\_ Phone: \_\_\_\_\_

Child care provider: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of siblings and school of attendance: \_\_\_\_\_

I verify that the information above is correct as printed and/or with the corrections as noted. Should any parent/guardian contact information change during the school year, I will notify the school office within one week.

➤➤• Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MEDICAL INFORMATION

Physician/Medical Group \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Medical Group I.D. Number \_\_\_\_\_ Local Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If your physician is not located in Davis, please name a local physician where your son/daughter may be taken for emergency care:

Davis Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

In the event of an accident or other emergency, when I/we are unavailable, I/we authorize a representative of the school to make such arrangements as he/she considers necessary for our son/daughter to receive medical or hospital care, including necessary transportation. Under such circumstances, we further authorize the physician/dentist named to undertake such care and treatment of my/our son/daughter as he/she considers necessary. In the event said physician is not available at the time, I/we authorize such care and treatment to be performed by any licensed physician/dentist or surgeon.

THE UNDERSIGNED HEREBY AGREE TO THESE PROCEDURES AND FURTHER AGREE TO BEAR ALL ACCIDENT/EMERGENCY COSTS INCURRED AS THE RESULT OF THE FOREGOING:

Signature of the Parent(s)/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

If you DO NOT choose to sign the above statement, please state action desired in the event of any accident or emergency \_\_\_\_\_

Signature of Parent(s)/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please answer Yes or No: Wears contact lenses \_\_\_\_\_; Wears hearing aid \_\_\_\_\_; Wears dental appliance \_\_\_\_\_. Subject to any conditions which may result in emergency such as Epilepsy; Diabetes; Fainting Spell; Heart Condition; Drug Allergy; Allergic Reaction to Insect Bites or Bee Stings; Hay fever or other health problems. PLEASE LIST ANY CONDITION AND WRITE SPECIAL INSTRUCTIONS, IF ANY:

Other known problems or medic alert information (speech, hearing, vision, orthopedic, bleeding tendency, etc.) Please list and explain:

Does the student take medication regularly? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, name the medication \_\_\_\_\_

Anticipated reactions, if any: \_\_\_\_\_