



EMERGENCY INFORMATION RECORD

Student

Name: _____ District of Residence: _____
(Last) (First)
Social Security Number: _____ Medicaid Number: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Date of Birth: _____ Male Female

Parent/Guardian Information (add addresses if different from child)

Father: _____ Home/Cell Phone: _____/
Home Address: _____ Business Phone: _____
email address: _____

Mother: _____ Home/Cell Phone: _____/
Home Address: _____ Business Phone: _____
email address: _____

Legal Guardian/Surrogate: _____ Daytime Phone: _____
Child lives with: Mother Father Both Other Please specify: _____

I give permission for the following person(s) to pick up this student in case of emergency, if I cannot be reached.

Name: _____ Home/Cell Phone: _____/
Address: _____ City: _____
Name: _____ Home/Cell Phone: _____/
Address: _____ City: _____

Medical

Student's Doctor: _____ Address: _____
Phone Number: _____

Does your child take medication? Yes (if yes, please list medication/s below) No

_____ Daily Dosage: _____
Daily Dosage: _____
Daily Dosage: _____

If given in school, what is the dosage? _____ What is medication for? _____

Is your child allergic to anything (e.g., food, medicine, animals)? Yes No
If yes, please specify: _____

Signature: _____ Date: _____