

EMERGENCY CARD

(This card needs to be completed every school year.)

School _____ Date _____

Grade _____ Room _____ Language Spoken at Home _____

Name _____
(Last) (First) (Middle Initial)

Sex: M ☐ F ☐ Birthdate

Month		Day		Year					

Home Address _____ Apt. No. _____ City _____ Zip Code _____

Mailing Address _____ Zip Code _____ Child resides with _____

Father's/Legal Guardian's Name:

Employer: _____

Active Duty: Yes ☐ No ☐ Branch of Military Service: _____

Home Phone: _____ Bus. Phone: _____

Cellular Phone: _____

E-mail Address: _____

Mother's/Legal Guardian's Name:

Employer: _____

Active Duty: Yes ☐ No ☐ Branch of Military Service: _____

Home Phone: _____ Bus. Phone: _____

Cellular Phone: _____

E-mail Address: _____

EMERGENCY CONTACTS: In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____

Family Physician _____ Phone _____ Dentist _____ Phone _____

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one.

To assure prompt attention to your child,

PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.

Parent's/Legal Guardian's Signature

Note: Please complete health information on back of card. ➡

INSURANCE INFORMATION:

My child has health insurance: ☐ Yes ☐ No If YES, check: ☐ QUEST/Medicaid **OR** ☐ Private

If private, check your plan: ☐ HMSA ☐ Kaiser ☐ Tri-Care ☐ Other _____

MEDICAL CONDITIONS:

☐ My child does not have any medical conditions.

☐ My child has a medical condition(s).

Please check below:

☐ Asthma

☐ Chronic Cough/Wheezing

☐ Hearing Problems

☐ Seizures

☐ Blood Disorders

☐ Diabetes Type I

☐ Heart Condition

☐ Skin Problems

☐ Bone/Joint Disorders

☐ Diabetes Type II

☐ High Blood Pressure

☐ Vision Problems

☐ Cancer/Leukemia

☐ Genetic Condition

☐ Metabolic Disorder

☐ Other _____

☐ **ALLERGIES:** ☐ Bee Sting ☐ Food ☐ Medications ☐ Other _____

For the above allergy(ies), reaction occurs by: ☐ Skin contact ☐ By inhalation ☐ By ingestion ☐ Other _____

Date of last reaction: _____

Describe the allergic reaction that occurs: _____

☐ **MEDICATION(S) TAKEN:**

My child takes the following medication(s): _____

Reason for taking the medication(s): _____

☐ **OTHER HEALTH CONCERNS:** _____

Other children:

Name

School

Grade
