

Emergency Health Information Form

Student's Name		Grade
Date of Birth		Home Phone
Address		
With whom does the child reside?		
Mother's Name	Daytime Phone	Cell Phone Email
Father's Name	Daytime Phone	Cell Phone Email
Name of local person, other than the parent or guardian, to call in case of emergency.		
Name		Phone
Name		Phone
Name		Phone
Name		Phone
Name of Physician to call in case of emergency		
		Phone
Name of Dentist to call in case of emergency		
		Phone
In case of emergency, which hospital would you prefer?		
Does your child have any allergies?		Yes No
If yes, please list:		
Does your child have any medication allergies?		Yes No
If yes, please list:		
Does your child have any allergies to bees or insects?		Yes No
If yes, please list:		
Does your child take medication regularly at home?		Yes No
If yes, please list:		
Does your child wear glasses?		Yes No
Does your child wear contact lenses?		Yes No
Does your child have any significant medical conditions or problems we should know about? i.e. any serious accident or illness, operations		Yes No
If yes, please explain:		

To Whom It May Concern: I give consent for my child, _____, to be treated medically in an emergency.

Parent/Guardian's Signature _____ Date _____