

HEALTH EMERGENCY

Student _____ Grade Entering _____
Last Name First Name

Parent/Legal Guardian _____

Cell Phone: _____ Alternate Phone Number: _____

Emergency contact, if parent/guardian cannot be reached: _____ Phone: _____

Name of Insurance Company: _____

Family Physician: _____ Phone: _____

Family Dentist: _____ Phone: _____

Does your student have any medical conditions or restrictions? YES NO
If yes, please explain

Does your student have any known allergies? YES NO If yes, list: _____

Is your student on ANY medications? YES NO If yes, list: _____

If yes, does daily medication need to be given during summer school hours? YES NO

Does your student have any vision problems? YES NO

Does your student have any hearing problems? YES NO

****If medications of any kind are given at school, a PHYSICIAN AUTHORIZATION FORM must be signed and renewed for each school year!**

In case of accident or serious illness, I request school personnel to contact me, alternate authorized persons, or the named physician. If it is impossible to contact me, authorized persons, or the physician, the school personnel may make emergency arrangements as necessary for my student.

Parent/Guardian Signature: _____ Date: _____

Please complete and return to school promptly.