Year ______ ______________________
(School)

SCHOOL EMERGENCY/MEDICAL AWARENESS CARD

Student's Name ______________________
□male □female (Last name) (First Name)

Parent's Name ______________________

Address ______________________

(City) (State) (Zip Code)

Home phone ______ Date of Birth ______

Mother's Work # ______ Pager/Cell ______

Father's Work # ______ Pager/Cell ______

Please list two other emergency contacts to be called if parents cannot be reached and the contact's relationship to the child. (REQUIRED)

(Name) (relationship) (phone)

(Name) (relationship) (phone)

IS THERE ANYTHING CONCERNING THE HEALTH OF YOUR CHILD THAT THE SCHOOL SHOULD KNOW?

____

I authorize the above information to be shared with teachers and staff. ______________________
(Parent/Guardian Signature)

Date ______

Teacher ______________________ Grade ______

Has your child had any illness or operation during the past year? □ NO □ YES (explain): ______

Allergies? □ NO □ YES (specify): ______

Medications regularly taken □ NO □ YES (specify): ______

Doctor to be called in case emergency: ______

Phone ______

Insurance Company ______

Child's ID # (if applies): ______

Name:

Date	in	RTC	Complaint	Assessment	Treatment	Provider	Home