

EMERGENCY/MEDICAL INFORMATION (Minors only)

Students Name _____

Birth Date MM/DD/YYYY _____

Address _____

Home Phone _____

Mother's Name _____

Cell/Bus Phone _____

Father's Name _____

Cell/Bus Phone _____

**IN CASE OF ILLNESS, PLEASE LIST NAMES AND TELEPHONE NUMBERS TO BE CALLED IN
EMERGENCY IF PARENT CANNOT BE REACHED**

Name _____

Address _____

Phone _____

Name _____

Address _____

Phone _____

In the event of an emergency and I cannot be reached, I give my permission for my son/daughter to be given immediate medical care at a hospital or other medical/dental facility

Doctor's Name _____ **Phone** _____

Date _____ **Parent/Guardian** _____

TO BE COMPLETED BY PARENT:

Medical/Orthopedic/Emotional Conditions _____

Explain _____

Allergies _____

Medication taken daily _____

Other comments _____

Date of last physical _____

Signature of Parent/Guardian _____

Date _____