Student Emergency Information Card

FOR OFFICE USE ONLY: AERIES G DATE _____BY _____

STUDENT'S LEGAL NAME (LAST – FIRST – MIDDLE)	BIRTH DATE (MM-DD-YY)	GRADE
ADDRESS (STREET – CITY – STATE – ZIP)	HOME PHONE	STUDENT'S CELL PHONE
MAILING ADDRESS (BOX OR STREET – CITY – STATE – ZIP)	STUDENT'S E-MAIL	
G CHECK IF THIS REFLECTS ADDRESS CHANGE	STUDENT'S SIGNATURE	STUDENT'S LICENSE PLATE NUMBER

FAMILY INFORMATION

G Father G Stepfather G Guardian — LIVING WITH STUDENT G Yes G No		
PARENT/GUARDIAN NAME		
ADDRESS, IF NOT LIVING WITH STUDENT (Street Address, City, Zip Code)		
HOME PHONE	PAGER	CELL PHONE
PARENT'S E-MAIL		
EMPLOYER	WORK PHONE	

G Mother G Stepmother G Guardian — LIVING WITH STUDENT G Yes G No		
PARENT/GUARDIAN NAME		
ADDRESS, IF NOT LIVING WITH STUDENT (Street Address, City, Zip Code)		
HOME PHONE	PAGER	CELL PHONE
PARENT'S E-MAIL		
EMPLOYER	WORK PHONE	

In case the student's parent/guardian cannot be reached, the school will contact and/or release the student to the following adults:

ADULT NAME	DAY-TIME PHONE	CELL PHONE	RELATIONSHIP TO STUDENT / FAMILY
1.			
2.			
3.			

≡ **COMPLETE OTHER SIDE** ≡

F5141.1A 8/85; Revised 5/19/10 (doc)

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Siblings: Name: _____ Age: _____ School: _____
Name: _____ Age: _____ School: _____
Name: _____ Age: _____ School: _____

MEDICAL INFORMATION *(please check **Yes** or **No**)*

Allergic Reactions	G Yes	G No	If yes, type of allergies: _____
Asthma	G Yes	G No	If yes, type of medication taken: _____
Diabetes	G Yes	G No	If yes, type of treatment: _____
Seizure Disorders	G Yes	G No	If yes, what type of seizure: _____
Medication taken regularly	G Yes	G No	If yes, list type(s) of medication, dosage, and schedule: _____

Note—If your child needs to take medication during the regular school day, a form must be signed by the parent/guardian AND the health care provider before the student can take the medication. You can obtain this form at the school office.

OTHER MEDICAL CONDITIONS: _____

DOCTOR: _____ Address: _____ Phone: ( ) _____

HEALTH INSURANCE CARRIER: _____ Policy Number: _____

I /WE authorize the District's authorized personnel to administer first aid and to obtain medical care for my child, _____ in the event of an emergency, illness, accident, or injury (including necessary transportation). I/WE authorize such care and treatment to be performed by any licensed physician or surgeon. I/WE agree to bear all costs incurred as a result of the foregoing.

Father / Guardian Signature *Date* *Mother / Guardian Signature* *Date*

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Siblings: Name: _____ Age: _____ School: _____
Name: _____ Age: _____ School: _____
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