

# Emergency Card

FOR OFFICE USE ONLY	
PHOTO	SUNSCREEN
Teacher	
Health Information determined	
Photo of Child	

Student's Last Name                      First                      Middle

Physical address

Mailing address if different from above

Birth Date

### Parents Information

Parent/ Legal Guardian #1 \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Parent/ Legal Guardian #2 \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Parent/ Legal Guardian #3 \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

### Emergency Contact Information

(child may be released to if legal guardian is unavailable)

Emergency Contact #1 \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship to child \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

### Child's usual source of medical care

Dr./Clinic \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Child's health insurance \_\_\_\_\_

Policy holder's name \_\_\_\_\_ Policy #: \_\_\_\_\_

Special conditions, disabilities, allergies, or medical information for emergency situations, if any

### Child's usual source of dental care

Dr. \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

### Parent/Legal Guardian consent and agreement for emergencies

As the Parent/Legal Guardian, I give my consent to have my child receive first aid by facility staff. If it should be deemed necessary, take my child to the appropriate medical facility at my expense. If I do not have a family physician, I understand there is a physician available 24 hours a day at the hospital. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contacts listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

\* Please note this information will be shared with the medical staff.

Signature of Parent/Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_ Revised 3/17 LMS