

EMERGENCY CARD

(This card needs to be completed every school year.)

Student Address Label

School _____ Date _____

Grade _____ Room _____ Language Spoken at Home _____

Name _____ Sex: M F Birthdate

Month	Day	Year

Home Address _____ Apt. No. _____ City _____ Zip Code _____

Mailing Address _____ Zip Code _____ Child resides with _____

Father's/Legal Guardian's Name: _____ Employer: _____ Active Duty: Yes <input type="checkbox"/> No <input type="checkbox"/> Branch of Military Service: _____ Home Phone: _____ Bus. Phone: _____ Cellular Phone: _____ E-mail Address: _____	Mother's/Legal Guardian's Name: _____ Employer: _____ Active Duty: Yes <input type="checkbox"/> No <input type="checkbox"/> Branch of Military Service: _____ Home Phone: _____ Bus. Phone: _____ Cellular Phone: _____ E-mail Address: _____
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EMERGENCY CONTACTS: In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

Name	Relationship	Phone
1. _____	_____	_____
2. _____	_____	_____

Family Physician _____ Phone _____ Dentist _____ Phone _____

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one.

To assure prompt attention to your child,

PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.

Parent's/Legal Guardian's Signature _____

Note: Please complete health information on back of card.

RS 17-1251, May 2017 (Rev. of RS 13-1113)

INSURANCE INFORMATION:

My child has health insurance: Yes No If YES, check: QUEST/Medicaid **OR** Private
If private, check your plan: HMSA Kaiser Tri-Care Other _____

MEDICAL CONDITIONS:

- My child does not have any medical conditions.
- My child has a medical condition(s).

Please check below:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Cough/Wheezing | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Diabetes Type I | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Bone/Joint Disorders | <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Cancer/Leukemia | <input type="checkbox"/> Genetic Condition | <input type="checkbox"/> Metabolic Disorder | <input type="checkbox"/> Other _____ |

- ALLERGIES:** Bee Sting Food Medications Other _____

For the above allergy(ies), reaction occurs by: Skin contact By inhalation By ingestion Other _____

Date of last reaction: _____

Describe the allergic reaction that occurs: _____

- MEDICATION(S) TAKEN:**

My child takes the following medication(s): _____

Reason for taking the medication(s): _____

- OTHER HEALTH CONCERNS:** _____

Other children:	Name	School	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____