EMERGENCY INFORMATION CARD SCHOOL YEAR__________

Name of Child______________________________ Date of Birth_________ Grade___
HomeAddress____Phone_____________

Mother/GuardianName_________________________________Cell________________
Mother's Place of Employment _______________________Phone_________________

Father/Guardian Name______________________________ Cell__________________
Father's Place of Employment _________________________Phone________________

Designated contact person if parent/guardian is unable to be reached during school hours in case of emergency, illness, or injury. This person is authorized to pick up the student from school as needed:
*Name*____________________________*Relationship*______________*Phone*_________
*Name*____________________________*Relationship*______________*Phone*_________
*Name*____________________________*Relationship*______________*Phone*_________

Health Care Provider _______________________________________Phone_________

I authorize the school nurse or school personnel to arrange for medical assistance or transportation to a hospital at my expense if needed. I understand that I must notify the school office and school nurse with any changes of the information above.
Parent / Guardian Signature_____________________________________Date_______

Rev. 2/2012cp **PLEASE TURN OVER AND COMPLETE THE OTHER SIDE.**

Does your child have health insurance? Yes_____ No ____
If yes, type of insurance - Private Ins. ________ Husky_________

Is your child taking any medication? yes_______ no______
Name of medications____
Medication Allergies and Symptoms____

Food allergies and symptoms____
Food allergy requires use of Epipen/Benadryl: yes________ no_______

Severe Bee Sting Allergy: yes______ no_______
Requires use of Epipen /Benadryl: yes_______ no_______

Asthma: yes______ no_____
If yes: Mild_____ Moderate_______ Severe_______ Exercise Induced_____
Date of last episode___________ Asthma Medication: yes_____ no_______

Seizures: yes____no____ Date of last seizure ______________Type_________________

Diabetes: yes___ no____ Use of insulin pump_____pen_____injection_____ other_____

Other special medical needs/considerations____________________________________

PLEASE NOTIFY THE SCHOOL OFFICE AND SCHOOL NURSE WITH ANY CHANGES.