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MEDICAL & EMERGENCY CONTACT FORM

Student Name _____ Grade _____ DOB _____

Parent/Guardian Name _____

Relationship to Student _____

Home # _____ Cell # _____ Work # _____

Email _____

Parent/Guardian Name _____

Relationship to Student _____

Home # _____ Cell # _____ Work # _____

Email _____

Health/Emergency Treatment Information

Child's Doctor _____ Phone # _____

Child's Dentist _____ Phone # _____

Hospital of Choice _____

Insurance Carrier _____ Policy # _____

Allergies Yes No If Yes, please list _____

Does your child carry an Epi-pen for their allergies? Yes No

What happens to your child when they have an allergic reaction? (swelling, itching, shortness of breath, etc.)

MEDICATIONS: Please list any medications that your child takes at home on a daily basis (i.e. Ritalin, Adderall, asthma inhalers, or over the counter medicines) _____
